87-1331

No.

Supreme Court, U.S.
FILED
FEB 8 1988
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

PAN-AMERICAN LIFE INSURANCE COMPANY

and

THE PAN-AMERICAN LIFE INSURANCE COMPANY EMPLOYEES' RETIREMENT PLAN,
Petitioners

v.

THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTION PRESENTED

Whether a federal district court has exclusive jurisdiction under 28 U.S.C. § 1331 (1982), as this is a suit arising under a federal law—the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (1982 & Supp. III 1985).

PARTIES TO THE PROCEEDINGS

The parties to these proceedings are petitioners, Pan-American Life Insurance Company and the Pan-American Life Insurance Company Employees Retirement Plan; and respondent, The Secretary of the Department of Health and Human Services. Joseph V. Morales, David Winters, Barkef K. Osigian, Camille Hubble, Ben F. McKown and the Class of non-vested Pan-American Life Insurance Company employees certified as a class by the district court also have an interest in these proceedings.

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v.

THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petitioners, Pan-American Life Insurance Company and the Pan-American Life Insurance Company Employees' Retirement Plan respectfully pray that a Writ of Certiorari be issued to review the granting of a Writ of Mandamus by the United States Court of Appeals for the Fifth Circuit entered in this case on September 25, 1987.

OPINIONS BELOW

The Minute Entry of the district court ordering the joinder of the Secretary of Health and Human Services as a plaintiff is reprinted as Appendix A hereto. The district court's order of February 25, 1987, denying the Secretary's Motion to Dismiss is reprinted as Appendix B hereto. The August 4, 1987 Minute Entry of the district court denying certification of its denial of the Secretary's Motion to Dismiss is reprinted as Appendix C hereto. The September 25, 1987 order of the Fifth Circuit Court of Appeals dismissing the Secretary of Health and Human Services is reprinted as Appendix D hereto. The October 8, 1987 opinion of the same panel denying a Motion for Clarification of its September 25, 1987 order is reprinted as Appendix E hereto. The November 12, 1987 order of the Fifth Circuit denying a rehearing and a rehearing *en banc* is reprinted as Appendix F hereto.

JURISDICTION

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) (1982). Jurisdiction of the District Court was based upon the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(e) (1982).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

Article III, § 2, cl. 1 of the Constitution of the United States in pertinent part provides:

> The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority;—to all Cases of admiralty and maritime Jurisdiction;—to Controversies to which the United States shall be a Party;—to Controversies between two or more States;—between a State and Citizens of another State;—between Citizens of different States;—be-

tween Citizens of the same State claiming Lands under Grants of different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.

The text of the following statutes relevant to the determination of the present case are reprinted as Appendix G hereto: Judicial Code, 28 U.S.C. §§ 1331 and 1345 (1982); section 502 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132 (1982 & Supp. III 1985) and section 10 of the Contract Disputes Act of 1978, 41 U.S.C. § 609 (1982).

STATEMENT OF THE CASE

1. Facts and the Underlying Dispute

At the heart of this dispute is a claim by former plan participants of the Pan-American Life Insurance Employees' Retirement Plan ("the PALIC Retirement Plan") brought under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (1982 & Supp. III 1985). (Complaint and Motion to Amend Complaint are reprinted as Appendix H at p. 16a). This action was originally filed by five former employees of Pan-American Life Insurance Company ("PALIC").[1] The former plan participants stake claim to an alleged six million dollars which they allege are pension benefits that should have been paid to them on account of work done by them for PALIC as part of a Medicare contract which PALIC had with the Secretary of Health and Human Services ("the Secretary").[2] The former plan par-

[1] The original plaintiffs, Joseph V. Morales, David Winters, Barkef K. Osigian, Camille Hubble and Ben F. McKown filed this action against PALIC and the PALIC Retirement Plan as a class action. The district court has certified all non-vested former plan participants as a class. All other classifications were denied by the district court.

[2] The original contract for the administration of the Medicare Program in Louisiana was entered into in 1966. This contract was renewed several times and often new contracts were entered into at renewal. In 1984 the Secretary terminated its contract with PALIC.

ticipants allege in their complaint that the six million dollars consist of three million dollars in allegedly withheld pension contributions and approximately three million dollars of interest on the allegedly withheld pension funds. These former plan participants claim that they are third-party beneficiaries to the contract between PALIC and the Secretary and are entitled to any overpayments made by the Secretary under that contract. PALIC contends that the participants vested under the PALIC Retirement Plan have received the benefits to which they were entitled under the Plan and that the non-vested participants are not due any benefits. The Secretary has laid a claim to the funds because of an alleged overpayment of pension costs to the PALIC Retirement Plan under its contracts with PALIC.[3] In the center of this three-way pull is approximately six million dollars held by the PALIC Retirement Plan. The Secretary has claimed that PALIC actually owes it an approximate three million dollars which it alleges it overpaid into the pension fund and which the plan participants claim PALIC allegedly did not disburse. Thus, both the Secretary and the former plan participants claim that they are entitled to the funds held by the PALIC Retirement Plan.

2. Proceedings Below

On January 20, 1987, the Secretary filed a Motion to Dismiss the Secretary as a plaintiff[4] in this action with-

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[3] The Secretary has prepared and issued a final audit of its eighteen-year contractual relationship with PALIC. That audit states that the Health Care Financing Administration, an agency of the Secretary, claims entitlement to the reimbursement of $2,678,135.00 Dollars. The Secretary claims that there was an overcontribution of pension costs by it to PALIC. The Secretary's audit of pension costs begins in 1966 and ends at the termination of the contract by it in 1984.

[4] The Secretary was made an involuntary plaintiff to these proceedings pursuant to Federal Rule of Civil Procedure 19. *See* November 3, 1986 Minute Entry, Appendix A at p. 1a. The original

out prejudice. The Secretary filed its Motion to Dismiss on the grounds that the federal district court did not have jurisdiction over the Secretary in this dispute.[5] Along with its Motion to Dismiss, the Secretary also filed a motion to appear in the suit as *amicus curiae.* (Reprinted as Appendix J at p. 58a).[6] On February 25, 1987, the Honorable Henry A. Mentz, Jr., United States District Judge, denied the Secretary's Motion to Dismiss and found its Motion to Appear as *Amicus Curiae* moot. *See* Appendix B at p. 2a. On June 5, 1987, the Secretary filed, pursuant to 28 U.S.C. § 1292(b) (1982), a Motion for Certification of the district court's denial. After hearing oral argument on two occasions, the district court denied the Secretary's Motion for Certification on August 5, 1987. *See* Appendix C at p. 3a. The Secretary then filed on September 4, 1987, a writ of mandamus in the Fifth Circuit Court of Appeals and requested that the Fifth Circuit issue a writ of mandamus directing the district court to dismiss the Secretary from

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plaintiffs in this matter, the Secretary and PALIC all stake a claim to the disputed funds. Thus, having all of the parties in one forum satisfied Rule 19's underlying policy of avoiding prejudice. *See* Fed. R. Civ. P. 19(b).

[5] *See* PALIC's Opposition to Writ of Mandamus at 2 n.1, *Morales v. Pan-American Life Ins. Co.*, No. 87-3658 (5th Cir.). (Reprinted as Appendix I at p. 33a).

[6] The Secretary in its Memorandum in Support of its Motion to Appear as *Amicus Curiae* filed with its Motion to Dismiss recognized that it was a necessary if not an indispensable party to the litigation. It asserted "In short, HHS has an interest in the amounts which are the subject of this litigation. Moreover, HHS's interests are not adequately represented by the plaintiffs or by PALIC. It is HHS's interest to reduce the amount for distribution to plaintiffs and to recover the amount itself from PALIC." *See* The Secretary's Memoradum In Support of Motion to Appear as *Amicus Curiae.* (Memorandum In Support of Motion to Appear as *Amicus Curiae* is reproduced as Appendix J at p. 58a).

this case under the guise of the Contract Dispute Act.[7] The writ of mandamus was directed to the district court's refusal to certify a jurisdictional issue to the Fifth Circuit. The district court refused certification because "an immediate appeal from this Court's ruling that it has jurisdiction over the Dept. of Health & Human Services' claim will not materially advance the ultimate termination of the litigation inasmuch as a reversal of this Court's ruling will result in two suits." *See* Appendix C at p. 3a.

On September 25, 1987, a three-judge panel of the United States Court of Appeals for the Fifth Circuit, without a hearing, granted the Secretary's writ of mandamus ordering the district court to dismiss the Secretary from the suit. *See* Appendix D at p. 5a. A clarification of this order was requested by petitioners, but was denied. The three-judge bench neither issued an opinion nor allowed briefing or argument on the jurisdictional issues which demand both a practical and equitable analysis. Petitioners filed a Motion for Reconsideration and a Suggestion for Rehearing *En Banc* on October 9, 1987. On November 12, 1987, the United States Fifth Circuit Court of Appeals denied rehearing. *See* Appendix F at 7a. In issuing its order, the Fifth Circuit decided distinct and novel jurisdictional issues never before addressed by this Court or any other federal court without briefing or argument. The Fifth Circuit ignored the exclusive jurisdiction which the district court had under ERISA over the entire dispute. Accordingly, petitioners urge this Court to grant a writ of certiorari to consider the jurisdictional issues cryptically cast aside by the Fifth Circuit.

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[7] 41 U.S.C. §§ 601-613 (1982 & Supp. III 1985). The Secretary in the writ of mandamus argued that the Contract Disputes Act governed any dispute between the Secretary and PALIC. The Secretary completely ignored the exclusive federal jurisdiction under ERISA.

REASONS FOR GRANTING THE WRIT

I. Introduction

The Fifth Circuit's dismissal of the Secretary under the Contract Disputes Act of 1978 ("CDA") conflicts with this Court's jurisdictional holding in *Metropolitan Life Ins. Co. v. Taylor*.[8] This Court in *Metropolitan Life* found that claims arising under ERISA have federal question jurisdiction and are properly heard in the district courts.[9] The Fifth Circuit implicitly found that the CDA pre-empted the exclusive grant of federal jurisdiction under the Employee Retirement Income Security Act of 1974 (ERISA).[10] It exceeded its authority by divesting the district court of Article III jurisdiction under ERISA by employing the CDA. The result is a split of an ERISA dispute into two fragmented claims: the claim by the Secretary over the ERISA funds in the Claims Court and the ERISA claim by the former PALIC plan participants in federal district court.

Moreover, the Fifth Circuit has created a juridical gap between this Court's opinions in *Metropolitan Life Ins. Co. v. Taylor*[11] and *Franchise Tax Board v. Constr. Laborer's Vacation Trust*.[12] In *Franchise Tax Board*, this Court found that federal question jurisdiction did not exist because there was no real ERISA dispute.[13] However, like *Metropolitan Life* there is a real ERISA dispute here. The Fifth Circuit has treated this ERISA claim as a hybrid dispute of the types of claims considered in *Metropolitan Life* and *Franchise Tax Board*.

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[8] 481 U.S. ——, 109 S.Ct. ——, 95 L. Ed. 2d 55 (1987).

[9] 481 U.S. at ——, 109 S.Ct. at ——, 95 L. Ed. 2d at 65.

[10] 29 U.S.C. § 1132(e) (1982).

[11] *See supra* note 8.

[12] 463 U.S. 1 (1983).

[13] *Id.*

Thus, consideration by this Court is demanded as this type of ERISA claim is a matter of first impression.

Given this Court's recent opinions regarding the expansive preemptive effect of ERISA,[14] the granting of this writ is compelling. Congress granted exclusive federal district court jurisdiction over claims involving ERISA.[15] The Fifth Circuit's order directly conflicts with Article III of the Constitution of the United States, the jurisprudence of this Court and the manifest intent of Congress.[16]

II. The United States District Court for the Eastern District of Louisiana Had Exclusive Federal Question Jurisdiction Under 28 U.S.C. § 1331 (1982) as Provided for by the Employee Retirement Income Security Act of 1975, 29 U.S.C. § 1001 *et seq.* (1982 & Supp. III 1985)

A. *Exclusive Federal Question Jurisdiction Exists Under ERISA*

This Court should grant a writ of certiorari as the jurisdictional questions raised in this matter are important ones. *See Hagans v. Lavine*, 415 U.S. 528, 532

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[14] *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. ——, 109 S.Ct. ——, 95 L.Ed. 2d 39 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. ——, 109 S.Ct. ——, 95 L.Ed. 2d 55 (1987); *see also, Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) (New York's Human Rights Law preempted by ERISA); *Massachusetts Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) (state law tort claims preempted by ERISA); *Caterpillar, Inc. v. Williams*, 107 S.Ct. 2425, 2430 (1987) ("Once an area of state law has been completely pre-empted, any claim purportedly based on that state law is considered, from its inception, a federal claim, and therefore arises under federal law." (Citation Omitted.)).

[15] 29 U.S.C. § 1132(e) (1982).

[16] Congress clearly expressed in 29 U.S.C. § 1132(e) (1982) that jurisdiction over ERISA disputes lies in the district courts. In ERISA's House Conference Report, the House of Representatives stated, "the U.S. district courts are to have . . . exclusive jurisdiction over . . . actions to enforce or clarify [ERISA] benefit rights . . . ." H.R. Conf. Rep. No. 1280, 93rd Cong., 2nd Sess. 2, *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639, 5107.

(1974). The former PALIC plan participants filed their Complaint under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (1982). As a result, federal question jurisdiction under 28 U.S.C. § 1331 and under Article III of the United States Constitution vested the district court with jurisdiction to consider the matter. The Secretary was joined as a necessary party plaintiff because it asserted claims adverse to PALIC and the PALIC Retirement Plan. The Secretary claims funds which are also claimed by the former plan particiapnts. The Fifth Circuit's dismissal of the Secretary is contrary to the jurisprudence of this Court, contrary to the clearly worded, statutory conferral of jurisdiction to the district court, and contrary to the United States Constitution in light of the Separation of Powers Doctrine [17] and Article III of the United States Constitution. Since Congress can legislatively confer jurisdiction on the federal courts to further its policies, the divestiture of jurisdiction by the Fifth Circuit impinges upon Congress' Constitutional powers.

In order for the district court to have federal question jurisdiction under 28 U.S.C. § 1331 (1982), the case must "arise under" the Constitution or some other aspect of federal law,[18] and this fact must appear on the face of a well-pleaded complaint. *Verlinden B.V. v. Central Bank of Nigeria*, 461 U.S. 480, 494-95 (1983). This

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[17] *Chadha v. Immigration and Naturalization Serv.*, 634 F.2d 408, 425 (9th Cir. 1980) (the court defined a violation of the separation of powers doctrine as an assumption of one branch of powers that are central or essential to the operation of a coordinate branch, provided also that the assumption disrupts the coordinate branch in the performance of its duties and is unnecessary to implement a legitimate policy of the Government), *aff'd*, 462 U.S. 919 (1983).

[18] *See, e.g., Textile Workers of America v. Lincoln Mills*, 353 U.S. 448 (1957) (Congressional power to regulate labor-management controversies under the commerce clause held to provide federal question jurisdiction under Article III, § 2 of the United States Constitution).

Court in *Textile Workers of America v. Lincoln Mills*[19] held that federal question jurisdiction existed in a dispute in which there was a Congressional policy to sanction parties who acted contrary to § 301 of the Labor Management Relations Act of 1947, 61 Stat. 156, 29 U.S.C. § 185 (1982). Analogous to the matter examined by this Court in *Lincoln Mills*, the dispute between PALIC, the Secretary and the former PALIC plan participants arises under a Congressional statute aimed at regulating pension plans. In ERISA, Congress clearly indicated that jurisdiction for disputes arising out of ERISA was to be in the United States district courts.[20] The Fifth Circuit's implicit determination that the district court did not have jurisdiction violates the separation of powers doctrine of the United States Constitution. The result is a judicial usurpation of the Fifth Circuit's powers by its superseding the constitutional powers of Congress. *See* U.S. Const. arts. I, II and III. As the Ninth Circuit explained in *Chadha v. Immigration and Naturalization Serv.*,[21] one branch of government cannot interfere with the powers of another branch when that interference disrupts the other branch's pursuit of policy aims through Constitutionally allowed powers.[22] To permit the Fifth Circuit to ignore the constitutionally permissible Congressional grant of jurisdiction would result in a violation of the separation of powers doctrine.[23]

This Court in *Baker v. Carr*[24] noted that

> [If a] complaint plainly sets forth a case arising under the Constitution, the subject matter is within

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[19] *Id.*

[20] *See supra* notes 15 and 16.

[21] *See supra* note 17.

[22] *See supra* note 17 and accompanying text.

[23] *See infra* note 38 and accompanying text.

[24] 369 U.S. 186, 200 (1962).

> the federal judicial power defined under Art. 3 § 2, *and so within the power of Congress to assign* to the jurisdiction of the District Courts. (Emphasis added).

The constitutional theory espoused by the *Baker* Court is invaded by the Fifth Circuit's dismissal of the Secretary. Similar to the matter in *Baker* where this Court found that Congress had authorized federal jurisdiction under 28 U.S.C. § 1343(3) (1982),[25] the jurisdiction over this entire dispute is authorized by Congress under 29 U.S.C. § 1132(e) (1982) and can only be heard in the federal district court.

Congress chose to regulate pension plans under ERISA and vest exclusive jurisdiction over such disputes in the district courts.[26] More recently, in this Court's October 1986 term, this Court held in *Pilot Life*[27] and *Metropolitan Life*[28] that ERISA preempts all state-law claims. These two decisions from this Court imply that ERISA claims are exclusively matters for the federal courts. To allow the Fifth Circuit to successfully convert a Congressionally regulated ERISA claim into a claim disingenuously made on behalf of the Secretary under the Contract Disputes Act usurps the Congressional power under Article III to confer jurisdiction to the federal courts and the congressional policy of regulating pension-plan disputes. More specifically, in *Metropolitan Life* this Court held:

> [A claim under ERISA] is necessarily federal in character by virtue of the clearly manifested intent of Congress. It, therefore, 'arise[s] under the . . .

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[25] The *Baker* Court pointed to 28 U.S.C. § 1343(3) (1982) as the basis for a Congressional grant of federal jurisdiction. *Baker*, 369 U.S. at 200.

[26] *See supra* notes 14, 15 and 16.

[27] *See supra* note 14.

[28] *See supra* notes 8 and 14.

> laws . . . of the United States,' 28 U.S.C. § 1331, and is removable to federal court by the defendants, 28 U.S.C. § 1441(b).

Metropolitan Life, 481 U.S. at ——, 109 S.Ct. at ——, 95 L. Ed. 2d at 65.[29] To allow the Fifth Circuit's dismissal of the Secretary in this dispute would be in direct conflict with this Court's recent holdings in *Pilot Life* and *Metropolitan Life*.[30]

The Secretary may argue that the relationship between it and PALIC was not governed by ERISA. Yet, the funds to which the Secretary has staked a claim are the object of a pension-plan dispute directly under ERISA. This matter is distinguishable from *Franchise Tax Board v. Construction Laborer's Vacation Trust*,[31] where there was no real ERISA dispute. In *Franchise Tax Board*, the trustees of an ERISA trust sought removal to federal district court on the grounds that ERISA governed their trust. At the heart of that dispute was the California tax board seeking to have the trustees comply with proper tax levies. Since there was no real ERISA dispute, this Court held that there was no federal jurisdiction. 463 U.S. at 25-26.

Here, the former PALIC plan participants have an ERISA claim. The Secretary has staked a claim to the same funds as those sought by the former PALIC Retirement Plan participants. The funds in dispute here are the object of an ERISA dispute. Thus, there is federal question jurisdiction under ERISA over the conflict-

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[29] *See also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

[30] Recently, several courts of appeal have read *Pilot Life* and *Metropolitan Life* as creating federal question jurisdiction due to ERISA's all-pervasive preemption. *See Texas Employers' Insurance Ass'n v. Jackson*, 820 F.2d 1406, 1419-20 (5th Cir. 1987); *Price v. PSA, Inc.*, 829 F.2d 871, 874-76 (9th Cir. 1987); *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987).

[31] 463 U.S. 1 (1983).

ing claims of the former plan participants and the Secretary to the funds held by the PALIC Retirement Plan. Congress intended for all ERISA claims to be tried in federal district court. Accordingly, the dispute over these pension funds should be tried in federal district court pursuant to ERISA.

The United States Third Circuit Court of Appeals in *Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*[32] found federal question jurisdiction because the dispute arose under the federal common law of ERISA. Since the claim before the court was related to employee benefit plans established under ERISA, the court held that the dispute arose out of the laws of the United States for the purposes of federal question jurisdiction under 28 U.S.C. § 1331 (1982). In *Northeast*, an employee benefit plan to which a wife was a participant sued the husband's plan to which the wife was a beneficiary for a declaration of the plans liability for medical expenses incurred by the wife. Finding no specific jurisdictional grant under ERISA, the Third-Circuit following this Court's opinion in *Shaw v. Delta Air Lines, Inc.*[33] and *Illinois v. City of Milwaukee*[34] found general federal question jurisdiction.[35]

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[32] 764 F.2d 147, 156-59 (3rd Cir. 1985).

[33] *See supra* note 29.

[34] 406 U.S. 91 (1972).

[35] The *Northeast* court found the *Illinois v. City of Milwaukee* principles applicable in ERISA related actions. 764 F.2d at 156. As aptly stated by that court,

> This certainly presents a matter of federal concern. Resolution of the issue will affect not only the interests of beneficiaries, whose welfare it was the prime purpose of ERISA to protect, but also the interests of benefit trust funds, the solvency of which was a matter of serious congressional concern.

764 F.2d at 158. Similarly, the resolution of the conflicting claims against the PALIC Retirement fund are matters of federal concern and should be resolved by the federal district court under ERISA.

There is a gap between *Metropolitan Life* and *Franchise Tax Board*. This dispute falls in that juridical gap. The funds in this dispute are the object of an ERISA claim. Both the former ERISA plan participants and the Secretary state a claim to those funds. PALIC asserts that exclusive federal jurisdiction exists in accord with *Pilot Life* and *Metropolitan Life*. The Secretary has contended that it does not. This dispute deserves consideration by this Court to eliminate the jurisdictional gap and to consider the Fifth Circuit's ruling which directly contravenes Article III of the United States Constitution, *Pilot Life*, *Metropolitan Life* and 29 U.S.C. 1132(e) (1982).

B. *Congressional Waiver of Immunity Under 28 U.S.C. § 1346 (1982)*

Moreover, when Congress has established statutory jurisdiction over the government, it has waived immunity under 28 U.S.C. § 1346 (1982). *See California v. Arizona*, 440 U.S. 59 (1979). This Court found in *California* that the government waives immunity to a suit in the district court whenever Congress has provided for such jurisdiction over the United States. Congress has in several matters granted federal courts exclusive jurisdiction so that suits may be filed only in the federal courts.[36] This Court in *Osborne v. Bank of the United States*[37] held that a federal court had jurisdiction since the bank in question was federally chartered. The Court held that since a federal law created the bank, every act on behalf of the bank, "[t]o use the language of the Con-

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[36] *See* 28 U.S.C. § 1334 (Supp. III 1985) (bankruptcy); 28 U.S.C. § 1338(a) (1982) (patent and copyright cases); 28 U.S.C. § 1351 (1982) (actions against consuls and vice consuls and members of a diplomatic mission); 18 U.S.C. § 3231 (1982) (federal crimes); and, 15 U.S.C. §§ 15, 26 (1982) (actions under certain antitrust statutes). *See generally* J. Friendenthal, M. Kane and A. Miller, *Civil Procedure*, §§ 2.1-2.4 (1985).

[37] 22 U.S. (9 Wheat) 739 (1824).

stitution, . . . arises out of this law." [38] While the *Osborne* decision may be considered attenuated, the matter before this Court is more of a federal question than was the *Osborne* dispute and is within the scope of Article III, § 2 of the United States Constitution and 28 U.S.C. § 1331 (1982).[39]

C. *Jurisdiction Under 28 U.S.C. § 1345 (1982): the United States as Plaintiff*

The Secretary has always been a plaintiff in these proceedings. As such, the district court had jurisdiction over the Secretary under 28 U.S.C. § 1345 (1982). Section 1345 provides original jurisdiction in the district courts in "all civil actions, suits or proceedings commenced by the United States, or by an agency or office thereof." 28 U.S.C. § 1345 (1982). This statute has been applied to actions in which the United States did not commence the action, but merely intervened.[40] The Secretary in this matter offered to be an *amicus curiae* in order to protect its interest while not subjecting itself to the district court's ruling. As the Secretary has indicated that it has an interest in the fund and a desire to participate in the district court, it should not be heard

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[38] 22 U.S. (9 Wheat) at 827.

[39] *Cf. Baker v. Carr*, 369 U.S. 186, 199 (1962) (citing *Newburyport Water Co. v. Newburyport*, 193 U.S. 561, 579 (1904):

> Dismissal of the complaint upon the ground of lack of jurisdiction of the subject matter would . . . be justified only if [the] claim [was] "so attenuated and unsubstantial as to be absolutely devoid of merit . . . ."

PALIC and the PALIC Retirement Plan submit to this Court that defendants such as PALIC and the PALIC Retirement Plan are entitled to the same standard of federal jurisdiction as was the plaintiff in *Baker*.

[40] *See Smith v. St. Luke's Hospital*, 480 F.Supp. 58 (N.D.S.D. 1979) (The district court acknowledged the United States' right to bring an action in federal court, yet chided the government for wanting to change its forum after voluntarily choosing one).

to complain of subjecting itself to the jurisdiction of the district court. The Secretary tried to participate as an *amicus curiae* in order to secure its interests without being under the jurisdiction and power of the district court. Such an approach was no more than a disguised voluntary intervention.[41]

D. *The Non-Retroactivity of the Contract Disputes Act*

The Secretary, ignoring the jurisdictional statutes of ERISA and the order of the district court, contended that PALIC was actually making a claim against the Secretary under the CDA which became effective March 1, 1979. Under the guise of the CDA, the Secretary convinced the Fifth Circuit to divest the district court of its jurisdiction under ERISA. Neither Congress nor any federal court has held that the CDA applies retroactively. However, the Fifth Circuit implicitly applied the CDA retroactively in its divestiture of the district court's ERISA jurisdiction.

Even if this was not an ERISA claim, the Contract Disputes Act does not apply to the majority of the contracts entered into between the Secretary and PALIC since they were formed prior to the effective date of the CDA. The CDA was enacted by Congress on November

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[41] *See, e.g., New Mexico v. Molybdenum Corp.*, 570 F.2d 1364 (10th Cir. 1978) (because of the interrelationship of interests between the rights of the plaintiff, defendant and the United States, the district court—using an interpleader analogy—aligned the United States as a plaintiff and found jurisdiction under 28 U.S.C. § 1345); *In re General Adjudication of all Rights to Use of Water*, 531 F.Supp. 449 (D.S.D. 1982) (jurisdiction under 28 U.S.C. § 1345 was established in a dispute in which the United States claimed a right to water usage since an action under § 1345 constituted a federal question). *See also Ashland Oil, Inc. v. Phillips Petroleum Co.*, 554 F.2d 381 (10th Cir. 1975), *cert. denied*, 434 U.S. 921 (1977) (jurisdiction under 28 U.S.C. § 1345 found in a commercial contract action in which the United States had a real interest).

1, 1978. Contract Disputes Act of 1978, Pub. L. 95-563, 92 Stat. 2383 (1978) (codified as amended at 41 U.S.C. §§ 601-613 (1982 & Supp. III 1985)). Section 16 of Pub. L. 95-563 provided the effective date of the Act as follows:

> This Act shall apply to contracts entered into 120 days after the date of enactment [November 1, 1978]. Notwithstanding any provision in a contract made before the effective date of this Act, *the contractor may elect* to proceed under this Act with respect to any claim pending then before the contracting officer or initiated thereafter. (Emphasis added).

Contract Disputes Act of 1978, Pub. L. 95-563, § 16, 92 Stat. 2383, 2391 (1978) (codified at 41 U.S.C. § 601 note (1982)). The Medicare contract entered into between PALIC and the Secretary was first put in contractual form in July of 1966. The contractual relationship was to be for a term of twenty years; however, in December of 1984, the Secretary terminated the Medicare contract. The contract entered into by PALIC and the Secretary in 1966 was renewed several times prior to the cancellation in 1984.[42]

The Secretary has argued that the CDA applies retroactively. However, such is not the case. Section 16 of the CDA specifically states that the act shall apply to contracts entered into 120 days after the date of the enactment, November 1, 1978, *i.e.* March 1, 1979. As Section 16 of the CDA provides only an option for a contractor to proceed under the Act, the Secretary cannot

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[42] The Secretary has asserted that the renewal contract entered into in 1980 and the provisions of that contract govern the entire contractual relationship since 1966. However, as evidenced by another renewal contract, provided by defendants to the district court on July 29, 1987, and included in the Appendix of this Petition as Appendix K, disputes can be resolved in any court of competent jurisdiction. *See* Appendix K at pp. 89a, 99a-100a. Petitioners submit that at the time of the renewal contract and of earlier contracts in existence prior to the CDA, the district court had jurisdiction to hear such disputes.

correctly assert that the claim retroactively applies and cannot elect to make any contracts written prior to the CDA subject to the CDA's provisions. *See Santa Fe, Inc. v. United States*, 13 Cl. Ct. 464 (1987) (the CDA applies to all contracts entered into, on or after March 1, 1979; for contracts entered into prior to the effective date of the Act, the contractor may elect to proceed under the Act with respect to any claim pending before a contracting officer as of March 1, 1979, or initiated thereafter).

As a result, the Secretary's argument under the CDA was nothing but a ruse which it used to divest the district court of Article III jurisdiction. Even if this was not an ERISA claim, which in and of itself vests exclusive jurisdiction in the United States district courts, this would have to be a claim made by PALIC who would then have an *option* to proceed under the CDA. PALIC is not compelled to bring any action under the CDA since its contract with the Secretary was entered into prior to March 1, 1979. Moreover, the CDA does not provide the Secretary as a plaintiff with a means of having a dispute heard in the United States Claims Court.[43] No court has ever applied the CDA retroactively. The Fifth Circuit's implicit retroactive application of the CDA supersedes the Congressional grant of jurisdiction in the federal district courts under ERISA and constitutes a *sub silentio* rejection of *Pilot Life* and *Metropolitan Life* as well as a partial repeal of 29 U.S.C. § 1132(e)(1982). Such action by the Fifth Circuit must be reversed by this Court.

CONCLUSION

The Fifth Circuit has rendered an order which conflicts with this Court's opinion in *Metropolitan Life*. It has created a conflict between ERISA and the CDA by displacing exclusive federal question jurisdiction under ERISA. Moreover, the Fifth Circuit has split an ERISA claim leaving one ERISA dispute in federal district

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[43] *See supra* Section C at p. 15.

court and the other to be resolved in the Claims Court. In light of *Metropolitan Life*, this Court should consider this case and reverse the Fifth Circuit's order which dismissed the Secretary from this dispute. Such action by this Court would resolve the open jurisdictional question between *Metropolitan Life* and *Franchise Tax Board.*

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Civil Action No. 85-3323

SECTION "I" (1)

JOSEPH V. MORALES, *et al.*

versus

PAN-AMERICAN LIFE INSURANCE COMPANY, *et al.*

Wednesday, October 29, 1986

10:00AM

MOTION OF DEFT, PAN AMERICAN LIFE INS. CO. AND THE PAN AMERICAN LIFE INS. CO. EMPLOYEES' RETIREMENT PLAN, TO DISMISS COUNT IV:

Argument—DENIED. Plaintiff to file amended complaint to add the Deparement of Health and Human Resources within 2 weeks.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Civil Action No. 85-3323

SECTION "I" (1)

JOSEPH V. MORALES, *et al.*

versus

PAN-AMERICAN LIFE INSURANCE COMPANY, *et al.*

Wednesday, February 25, 1987

10:00 AM

AMENDED

3. a) MOTION OF SECRETARY OF DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADM., TO DISMISS HHS AS A PLAINTIFF:

b) AMICUS SECRETARY OF DEPT. OF HEALTH AND HUMAN SERVICES' MOTION TO STAY PROCEEDINGS ON DAMAGES:

c) SECRETARY OF DEPT. OF HHS' MOTION TO APPEAR AS AMICUS CURIAE:

c) MOTION OF SECRETARY OF DEPT. OF HHS TO QUASH SUMMONS:

a) Argument—DENIED. *DEPT. OF HHS SHALL BE JOINED AS A NECESSARY PARTY PLAINTIFF.*

b) and c)—MOOT

d) GRANTED.

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Civil Action No. 85-3323

SECTION "I"

JOSEPH V. MORALES, *et al.*

versus

PAN-AMERICAN LIFE INSURANCE COMPANY, *et al.*

[Filed Aug. 5, 1987]

MINUTE ENTRY

August 4, 1987—Mentz, J.

A status conference was held on July 29, 1987 in the above-captioned matter.

Present: Frank Liberto for Plaintiffs
Eve Masinter and Dermot S. McGlinchey for Pan-American Life Insurance Company
M. Susan Burnett and Jeffrey Robbins for Dept. of Health & Human Services

The Court and counsel discussed the present posture of this action. Dept. of Health & Human Services submitted the final audit of pension costs claimed by Pan-American Life Insurance Co. The Court heard additional argument on Dept. of Health & Human Services' motion for certification. Accordingly,

IT IS ORDERED that:

(1) Dept. of Health & Human Services' motion for certification is DENIED. The question of whether Dept. of Health & Human Services' claim against Pan-American or the funds held by Pan-American is within the exclusive jurisdiction of the Court of Claims involves a controlling question of law as to which there is a substantial ground for difference of opinion. However, an immediate appeal from this Court's ruling that it has jurisdiction over Dept. of Health & Human Services' claim will not materially advance the ultimate termination of the litigation inasmuch as a reversal of this Court's ruling will result in two suits—one in the Eastern District of Louisiana, and one in the Court of Claims. Thus, the prerequisites for certification pursuant to 28 U.S.C. § 1292(b) have not been met.

(2) Considering that the final audit has been issued, the stay of this matter is LIFTED.

(3) Counsel for plaintiff shall prepare a draft of notification of the class.

(4) Dept. of Health & Human Services shall recommend that the final determination letter not be issued prior to resolution of the certification issue.

(5) Trial set for October 8, 1987 is CONTINUED to MONDAY, MARCH 21, 1988 at 9:00 a.m. before the District Judge without a jury. Trial is estimated to last one week.

(6) The pre-trial conference set for September 24, 1987 is CONVERTED to a status conference.

/s/ H.M.

Clerk to serve all counsel.

APPENDIX D

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 87-3658

USDC #CA 85-3323 I

IN RE: SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner.

[Filed Sept. 25, 1987]

On Petition for Writ of Mandamus to the United States District Court for the Eastern District of Louisiana

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Before: WILLIAMS, HIGGINBOTHAM and JONES, Circuit Judges.

BY THE COURT:

IT IS ORDERED that the petition for writ of mandamus is GRANTED as the only available means to accomplish review of the district court's jurisdiction at this stage of the proceedings.

APPENDIX E

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 87-3658

IN RE: SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner.

[Filed Oct. 8, 1987]

Appeal from the United States District Court
for the Eastern District of Louisiana

Before: WILLIAMS, HIGGINBOTHAM and JONES, Circuit Judges.

BY THE COURT:

IT IS ORDERED that the motion of Pan-American Life Insurance Company and the Pan-American Life Insurance Company Employees Retirement Plan for Clarification of the Court's order of September 25, 1987, is denied. By its order of September 25, 1987, the Court granted a writ of mandamus directing the District Court to dismiss the Secretary of Health and Human Services from the suit. USDC # CA 85-3323 I.

APPENDIX F

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 87-3658

IN RE: SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner.

Appeal from the United States District Court
for the Eastern District of Louisiana

ON PETITION FOR REHEARING AND
SUGGESTION FOR REHEARING EN BANC

(Opinion September 25, 5 Cir., 1987, —— F.2d ——)

(November 12, 1987)

Before WILLIAMS, HIGGINBOTHAM and JONES, Circuit Judges.

PER CURIAM:

(X) The Petition for Rehearing is DENIED and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc, (Federal Rules of Appellate Procedure and Local Rule 35) the Suggestion for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

/s/ J. Williams
United States Circuit Judge

APPENDIX G

STATUTORY PROVISIONS INVOLVED

Judicial Code

28 U.S.C. § 1331

> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28 U.S.C. § 1345

> Except as otherwise provided by Act of Congress, the district courts shall have original jurisdiction of all civil actions, suits or proceedings commenced by the United States, or by any agency or officer thereof expressly authorized to sue by Act of Congress.

29 U.S.C. § 1132

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1009 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any pro-

vision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respct [sic] to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority

on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) Administrator's refusal to supply requested information

Any administrator (1) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title with respect to a participant or beneficiary, or (2) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena [sic], or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service

upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(c) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other

than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved (as defined in section 4975(f)(4) of Title 26); except that if the transaction is not corrected (in such manner as the Secretary shall prescribe by regulation, which regulations shall be consistent with section 4975 (f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

41 U.S.C. § 609

(a) Actions in United States Claims Court; district court actions; time for filing

(1) Except as provided in paragraph (2), and in lieu of appealing the decision of the contracting officer under section 605 of this title to an agency board, a contractor may bring an action directly on the claim in the United States Claims Court, notwithstanding any contract provision, regulation, or rule of law to the contrary.

(2) In the case of an action against the Tennessee Valley Authority, the contractor may only bring an action directly on the claim in a United States district court pursuant to section 1337 of title 28, notwithstanding any contract provision, regulation, or rule of law to the contrary.

(3) Any action under paragraph (1) or (2) shall be filed within twelve months from the date of the receipt by the contractor of the decision of the contracting officer concerning the claim, and shall proceed de novo in accordance with the rules of the appropriate court.

(b) Finality of board decision

In the event of an appeal by a contractor or the Government from a decision of any agency board pursuant

to section 607 of this title, notwithstanding any contract provision, regulation, or rules of law to the contrary, the decision of the agency board on any question of law shall not be final or conclusive, but the decision on any question of fact shall be final and conclusive and shall not be set aside unless the decision is fraudulent, or arbitrary, or capricious, or so grossly erroneous as to necessarily imply bad faith, or if such decision is not supported by substantial evidence.

(c) Remand or retention of case

In any appeal by a contractor or the Government from a decision of an agency board pursuant to section 607 of this title, the court may render an opinion and judgment and remand the case for further action by the agency board or by the executive agency as appropriate, with such direction as the court considers just and proper.

(d) Consolidation

If two or more suits arising from one contract are filed in the United States Claims Court and one or more agency boards, for the convenience of parties or witnesses or in the interest of justice, the United States Claims Court may order the consolidation of such suits in that court or transfer any suits to or among the agency boards involved.

(e) Judgments as to fewer than all claims

In any suit filed pursuant to this chapter involving two or more claims, counterclaims, cross-claims, or third-party claims, and where a portion of one such claim can be divided for purposes of decision or judgment, and in any such suit where multiple parties are involved, the court, whenever such action is appropriate, may enter a judgment as to one or more but fewer than all of the claims, portions thereof, or parties.

APPENDIX H

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Civil Action 85-3323

SECTION "I" (1)

JOSEPH V. MORALES, DAVID WINTERS, BARKEF K. OSIGIAN, CAMILLE HUBBLE and BEN F. MCKOWN

vs.

PAN-AMERICAN LIFE INSURANCE COMPANY and THE PAN-AMERICAN LIFE INSURANCE EMPLOYEES' RETIREMENT BENEFIT PLAN

COMPLAINT—CLASS ACTION

1.

JOSEPH V. MORALES, DAVID WINTERS, BARKEF K. OSIGIAN, CAMILLE HUBBLE and BEN F. McKOWN, are each citizens of the United States and reside in the Eastern District of Louisiana and, on information and belief, the class they represent are citizens of the United States and reside in the Eastern District of Louisiana

2.

PAN-AMERICAN LIFE INSURANCE COMPANY, is a domestic insurance company with its principal place of business in the Eastern District of Louisiana.

3.

PAN-AMERICAN LIFE INSURANCE COMPANY EMPLOYEES' RETIREMENT PLAN, (hereinafter sometimes referred to as the "Pension Plan"), is a plan intended to qualify under Section 401(a) of the Internal

Revenue Code of 1954 for the purpose of providing retirement benefits and other incidental benefits for employees of the PAN-AMERICAN LIFE INSURANCE COMPANY.

4.

This action is brought for penalties and actual damages under 29 USC, Sec. 1132 et seq.

5.

Each named plaintiff and class member was a participant of the Pan-American Life Insurance Company Pension Plan.

6.

Each named plaintiff was employed by Pan-American Life Insurance Company in the administration of the Medicare Program specifically pursuant to an agreement under Section 1842 of the Social Security Act, as amended, between the Secretary of Health and Human Services and Pan-American Life Insurance Company, bearing Agreement Number HCFA 80-313-2. Exhibit 1 attached.

7.

Under the agreement, HCFA 80-313-2, Pan-American Life was among other things, to receive, disburse and account for funds in making Medicare payments in the State of Louisiana, make determinations as to coverage, determine reasonable charges with respect to medical services, institute utilization safeguards including methods for professionally assuring that payments are medically necessary; adjust underpayments and recover overpayments; and perform other functions necessary to carry out the purposes of the agreement.

8.

Pan-American Life's Medicare contract with the Government began on or about July 1, 1966, and continued until its termination on December 31, 1984.

9.

The Agreement, HCFA 80-313-2 was a "cost only" contract as specified in Article XVI agreeing that Pan-American Life Insurance shall be paid its cost of administration under the principle of neither profit nor loss to Pan-American Life Insurance Company.

10.

Immediately prior to the termination of the contract, HFC 80-313-2, on or about December 31, 1984, Pan-American Life Insurance Company employed approximately 100 employees to administer the contract provisions of Medicare for the State of Louisiana.

11.

The contract, HCFA 80-313-2 specifically provided in its Appendix B, Section 1118.7 under Deferred Compensation, contributions to pension plans.

12.

In addition to covering the salaries of these approximately 100 employees, the United States Government, on behalf of each of the employees, also contributed an additional 9.4% to 14.2% of the salary of each employee as a contribution to the Pension Plan.

13.

For the entire staff which administered the Medicare Program, the following tabulation gives the calculation of the pension contribution made on behalf of all Medicare employees by the United States Government.

Fiscal Year	Salaries	Pension Rate	Pension Contribution
1967	$ 451,050	10%	$ 45,105
1968	720,756	10%	72,076
1969	783,193	10%	78,319
1970	724,015	10.9%	78,920
1971	779,766	10.9%	84,994
1972	833,692	11.1%	92,540
1973	892,764	10.9%	97,311
1974	971,721	10.1%	98,144
1975	1,184.708	9.4%	111,363
1976	1,278,429	10.4%	132,957
1977	1,611,198	10.2%	164,342
1978	1,818.806	11.3%	205,539
1979	1,793,120	11.8%	211,588
1980	1,888.346	11.6%	219,048
1981	2,213,387	11.8%	261,180
1982	2,399,580	10.1%	242,358
1983	2,648,722	12.1%	320,495
1984	2,701.623	14.2%	383,630
*1985	728,237	13.8%	100,496
			$3,000,398

*Estimate

14.

In addition to the approximately $3,000,398 contributed by the Federal Government to the Pension Plan, that money accrued interest at a rate of interest stated in the annual reports of Pan-American Life Insurance Company in accord with the following table:

Fiscal Year	Interest Rate	Amount
1967	6.17%	$ 1,376
1968	6.9%	5,693
1969	7.6%	12,419
1970	8.34%	21,220
1971	9.5%	33,974
1972	9.53%	45,778
1973	9.33%	57,944
1974	9.0%	69,906
1975	9.29%	88,383
1976	10.08%	117,122
1977	6.85%	97,797
1978	7.11%	121,611
1979	9.0%	183,654
1980	10.06%	245,422
1981	14.0%	409,516
1982	14.5%	520,028
1983	9.74%	427,377
1984	13.5%	697,585
1985	13.5%	206,109
		$3,362,914

15.

During the course of the 18½ year period of the Medicare Contract, Pan-American Life received more than $3,000,000 in pension contributions from the Federal Government for the Medicare Department employees. Over the 18½ year period those contributions drew interest in excess of $3,300,000. The combination of contribution and interest exceeds $6,300,000 accumulated by Pan-American Life in this pension fund.

16.

On or about December 31, 1984, when Pan-American Life Insurance Company lost the Medicare contract to Arkansas Blue Cross, Pan-American Life terminated the approximately 100 employees in the Medicare Department.

17.

Pan-American Life Insurance Company's pension liability for "vested" terminated Medicare employees is less than $1,000,000, according to its calculation and its definition of a "vested interest".

18.

As a result of the Government contribution and the termination by Pan-American Life of almost the entire department, Pan-American Life and/or Benefit Plan stands to profit and be unjustly enriched in an amount in excess of $5,000,000. This unjust enrichment constitutes a profit and specifically violates Article XVI of HCFA 80-313-2.

19.

Plaintiffs have made a claim for benefits due them and a claim for a partial terminaiton of the retirement plan and this has been denied in writing by Ted Tuminello, Chairman of the Pension Committee.

20.

The Pension Committee, pursuant to Article 14.05 is the Plan Administrator pursuant to the Employees Retirement Benefit Plan. Therefore, named plaintiffs have exhausted all internal administrative remedies pursuant to Article 7.02 "Claim Procedures" under the Employees Retirement Benefit Plan.

CLASS ACTION ALLEGATIONS

21.

This action is filed under the Provisions of Rule 23(b)(2) and (3) of the Federal Rules of Civil Procedure for Injunctive and Declaratory Relief and for the penalties and actual damages as prescribed by the act and all amendments thereto.

22.

The same denial of benefits was given to all class members by Pan-American Life Pension Committee and the Plan Administrator.

23.

The penalty class and actual damage class will be composed of all employees of Pan-American Life who administered the Medicare Contract, HCFA 80-313-2 and who were terminated on or about December 31, 1984, as well as those members of the Medicare Department who were on the transition team and were terminated on February 15, 1985.

24.

The size of the entire class is not known by plaintiffs but estimates it will contain approximately 100 members.

25.

The entire class is broken into three sub-classes, each with a named plaintiff as class representative.

a) The A Class consists of those class members in the general class whose rights under the benefit program had vested but whose lump sum vesting amount exceeded $20,000 and were required by the plan to therefore accept only the annuity upon reaching age 65 or earlier if they attained credited years of service in accordance with the Pan-American Pension Plan;

b) The B Class shall consist of the general class members whose benefits had vested but whose lump sum was less than $20,000 and were given the opportunity to take either the lump sum or an annuity upon reaching age 65;

c) The C Class shall consist of those general class members whose funds, as contributed by the Federal Government and interest accumulated thereon, were not considered vested by Pan-American Life or the Pension Committee.

26.

The Class Representatives for the A Class are Morales, Osigian and Winters. The Class Representative for the B Class is Ben McKown and the Class Representative for the C Class is Camille Hubble.

27.

Plaintiffs and their attorneys will adequately represent the Class, and they do not have any interest that are antagonistic to the members of any class or sub-class.

28.

Defendants' violations of the act and regulations will apply to each member of the class since the rejection was uniform and pursuant to the same Employees Benefit Program and pursuant to the same Medicare Contract.

29.

The interest of the named plaintiffs and each member of the class or sub-class will be controlling, the same questions of law will be involved as to each member of each sub-class. These issues will predominate over any other issues. The names and addresses of each class member are contained in records and files of defendants. Plaintiffs have the names of the majority of class members in any event. The Class Action is superior to and specifically provided and authorized by statute and will provide for the efficient and fair adjudication of plaintiffs' rights and the rights of each member of the class and sub-class thereby conserving the Court's time rather than if each member of the class filed a separate and distinct complaint. Congress, in specifically providing for class actions, has indicated the desirability of concentrating this relief for its prophylactic effect in carrying out national policies with respect to government contracts. There should be minimal management difficulties since almost all the members of the class will be located in the New Orleans Metropolitan area, have worked in the same area and same department up to 18 years and know one another very well.

Count I

30.

Plaintiffs repeat and reallege each of the preceding allegations as though stated in full herein.

31.

The closing down of the Medicare Administration Group of approximately 100 employees and the termination of all but one or two of those employees, constitutes a partial termination of the Pension Plan.

32.

As a result of the partial termination of the Plan, pursuant to 29 U.S.C. Sec. 1344, there should be an allocation of assets among the participants and beneficiaries of the plan as delineated in that section.

33.

The amount of the contribution to the plan is exactly delineated because the government, under the Medicare contract, contributed all of the funds for these participants into the pension plan. Therefore, an exact dollar amount of the contributions is available for the terminated portion of the plan.

34.

Each named plaintiff and each class member would participate in the allocation of assets for the partial termination of this plan.

Count II

35.

Plaintiffs repeat and reallege each of the preceding allegations as though set forth in full herein.

36.

The fiduciaries and the plan administrator for the Pan-American Life Insurance Employees Retirement Benefit Plan have arbitrarily enacted applications of eligibility requirements for the pension plan.

37.

With respect to the class members in the A Sub-Class, the pension plan, the fiduciaries and a plan administrator require that where a lump sum vesting amount exceeded

$20,000, those individuals were required to accept only the annuity upon reaching age 65.

38.

This provision is arbitrary and capricious.

39.

The imposition of a ceiling above which no lump sum payments will be made, diminishes the value that these Class A Sub Class members would receive.

40.

If they were to receive the actual lump sum, which is due and owing to them, they could reinvest these sums to have them appreciate in value over the succeeding years.

41.

By precluding the distribution of a lump sum, if that lump sum exceeds $20,000, the pension plan is arbitrarily diminishing and fixing the amount of funds at an arbitrarily low level that the Class A members would receive.

42.

There is no sound reason or reasonableness to the arbitrary limitation of $20,000, above which no lump sum would be distributed.

43.

Therefore, the Class members in the A Sub Class call for immediate payment of their lump sum values as determined by the Federal Government pension contributions made on behalf of each of these employees and interest accumulated thereon.

Count III

44.

Plaintiffs repeat and reallege each of the preceding allegations as set forth in full herein.

45.

With respect to the class members and the B Sub Class, the fiduciaries and plan administrator have required those members where a lump sum vesting amount was less than $20,000 to execute a release releasing the pension plan from any further claims in order to obtain monies which belonged to the class member of right.

46.

Those members who have executed such improper releases in order to obtain the lump sum benefit which was rightfully theirs should be permitted to participate in the B Class also.

47.

Since those B Class members had an absolute right to the lump sum which they collected, there was no consideration for the execution of the release and it is invalid as a matter of law.

48.

The forcing of the B Sub Class members to execute the release as a condition precedent to obtaining their rightfully vested funds in an arbitrary and capricious condition.

49.

Therefore, the Class members in the B Sub Class should include all those individuals who have been paid their lump sum whether or not they have executed a release of claims.

Count IV

50.

Plaintiffs repeat and reallege each of the preceding allegations as though set forth in full herein. Since the entire Pension Plan has been unjustly enriched in an amount in excess of $5,000,000 and this unjust enrichment constitutes a profit and specifically violates Article XVI of HCFA 80-313-2, plaintiffs claim a cause of action in contract as third party beneficiaries for the profit earned by this plan.

51.

The funds the Government paid into the Pension Plan for the Medicare employees would have gone to the Medicare employees as compensation, but for the pension plan.

52.

Pan-American Life contractually agreed with the Government that it would take no profit under Article XVI of HCFA 80-313-2, the Medicare contract.

53.

The named plaintiffs, individually and on behalf of each class member, claimed under contract the profits that Pan-American Life, for itself and for the benefit plan, have accumulated in excess of $5,000,000.

JURY TRIAL

53.

Plaintiffs are entitled to and demand a trial by jury for each count contained herein.

WHEREFORE, after due proceedings are had herein, Plaintiffs pray that the Class Action be maintained as a class action for all sub classes, and further that judgment be granted to Plaintiffs individually, and as representatives of all class members, in the amount of SIX MILLION, THREE HUNDRED THOUSAND

($6,300,000). DOLLARS, less any proceeds already paid to class members or Medicare employees and against Pan-American Life Insurance Company and the Pan-American Life Insurance Company Employees Retirement Benefit Plan, and for a trial by Jury and for all costs and reasonable attorneys fees, and all penalties provided, and for all general and equitable relief.

/s/ Frank Liberto
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Please Serve:

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through Mr. Donald Gibson, Secretary
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Pan-American Life Insurance Company
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601 Poydras Street
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Secretary of Labor
Washington, D.C. 20210

Secretary of the Treasury
Washington, D.C. 20210

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Civil Action No. 85-3323

SECTION "I" (1)

JOSEPH V. MORALES, *et al.*

versus

PAN-AMERICAN LIFE INSURANCE COMPANY

[Filed Nov. 10, 1986]

MOTION TO AMEND COMPLAINT PURSUANT TO ORDER OF COURT

Pursuant to Rule 19(a) (Necessary Parties) and Rule 15(a) (Amendments) of the Federal Rules of Civil Procedure, on behalf of Plaintiffs and all others similarly situated, plaintiffs requests [sic] that the following paragraphs be added as amendments to their complaint. The purpose of these amendments is to bring into this action the Department of Health & Human Services (DHHS), and the Health Care Financing Administration (HCFA), an agency within the Department of Health & Human Services. Plaintiffs wish to add the following paragraphs:

54.

A preliminary report prepared by the Office of Inspector General, Office of Audit, Region VII, under the Department of Health & Human Services has indicated an over-contribution by Medicare to Pan-American Life Insurance Company for funding of the Pan-American Life Insurance Company Pension Fund in the amount of $2,759,828.00.

55.

Plaintiffs' claim for $6,300,000.00 include [sic] the amount $2,759,828.00 claimed by HCFA of Pan-American Life Insurance Company.

56.

The current holders of these funds claimed by both plaintiffs and HCFA are Pan-American Life Insurance Company and the Pan-American Life Insurance Company Employee Retirement Benefit Plan.

57.

The Secretary of the Department of Health and Human Services, Health Care Financing Administration Agency is hereby added as a party plaintiff with respect to its claim against Pan-American Life Insurance Company under the Medicare contract (Agreement HCFA 80-313-2 as amended) for the repayment or refund of any amounts claimed to be due from Pan-American Life Insurance Company to the Department of Health and Human Services, Health Care Financing Administration Agency attributable to pension costs, including the tentative claim for approximately $2,759,828 asserted in its preliminary report on the Audit of Pension Costs.

/s/ Frank Liberto
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ORDER

Considering the above and foregoing:

IT IS HEREBY ORDERED that the above paragraphs 54 through 57 be added to plaintiffs' complaint and that the complaint, as amended, be served upon the Secretary of the Department of Health and Human Services, Health Care Financing Administration Agency, and that the Department of Health and Human Services make an appearance in this action and be required to plead (or otherwise defend) its claim for $2,759,828.00 in this action.

New Orleans, Louisiana, this 13th day of November, 1986.

/s/ Henry A. Mentz, Jr.
Judge

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing Motion to Amend Complaint Pursuant to Order of Court, has been forwarded to all opposing counsel, by depositing same in the U.S. mail, postage prepaid, properly addressed, this 10th day of November, 1986.

/s/ Frank Liberto
PETER FRANK LIBERTO

APPENDIX I

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 87-3658

JOSEPH V. MORALES, *et al.*,
Plaintiffs

versus

PAN-AMERICAN LIFE INSURANCE COMPANY, *et al.*,
Defendants

OPPOSITION TO WRIT OF MANDAMUS

[Filed Sept. 4, 1987]

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CERTIFICATE OF INTERESTED PERSONS

The undersigned, counsel of record, certifies that the following list of persons have an interest in the outcome of this case. There [sic] representations are made in order that the Judges of this Court may evaluate possible disqualification or recusal.

PARTIES

1. Pan-American Life Insurance Company and the Pan-American Life Insurance Company Employees Retirement Plan;
2. Joseph V. Morales, David Winters, Barkef K. Osigian, Camille Hubble and Ben F. McKown
3. Class of non-vested Pan-American Life Insurance Company employees certified as a class by the district court;
4. The Secretary of the Department of Health and Human Services, Health Care Financing Administration.

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STATEMENT OF ISSUES

1. Whether a Writ of Mandamus is the appropriate remedy for the Secretary to appeal the district court's denial of the Secretary's Motion for Certification?

2. Whether certification for interlocutory appeal would have been appropriate for the district court's denial of the Secretary's Motion to Dismiss?

OPPOSITION TO WRIT OF MANDAMUS

FACTS

On January 20, 1987, the Secretary of the Department of Health and Human Services ("the Secretary") filed a Motion to Dismiss the Secretary as a plaintiff in this action without prejudice. The Secretary filed its Motion to Dismiss based on the grounds that the federal district court did not have jurisdiction over the Secretary in this dispute.[1] On February 25, 1987, the Honor-

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[1] The underlying dispute in this matter concerns a claim by plaintiffs in this action under the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et. seq.*, for funds which allegedly were not paid to them by the Pan American Life Insurance Company Employees Retirement Plan. Further, the plaintiffs claim that they are entitled to funds held by the Plan as third-party beneficiaries to the contract between PALIC and the Secretary. (*See* Complaint, Amended Complaint, defendants' Memorandum in Opposition to Class Certification and Opposition Memorandum to the Secretary's Motion to Dismiss attached as Exhibits A, B, C & D). The Secretary was made an involuntary plaintiff by the district court in this action since it has made a claim to the same funds plaintiffs' claim they are due and which the Plan holds. The Secretary asserts that the contract between it and Pan American Life Insurance Company falls under the Contract Disputes Act 41 U.S.C. § 601 ("CDA"). Pan American Life Insurance Company contends that the CDA does not apply to the majority of the contract relationship between the Secretary and Pan American Life Insurance Company as the original contract was entered into in 1966, and was renewed several times, the last contract having been executed in 1980. Thus, the CDA did not affect the contract until 1980.

able Henry A. Mentz, Jr., U.S. District Judge, denied the Secretary's Motion to Dismiss. On June 5, 1987 the Secretary filed, pursuant to 28 U.S.C. § 1292(b), a Motion for Certification of the district court's denial of the Secretary's Motion to Dismiss for appeal to this Court. Judge Mentz heard oral argument on July 8, 1987. The district court reserved judgment on the Secretary's Motion and set a status conference for July 29, 1987. At the status conference, the district judge again heard argument on the Secretary's Motion for Certification. In a Minute Entry dated August 5, 2987, Judge Mentz denied the Secretary's Motion for Certification because certification of the denial of the Secretary's Dismissal *would not materialy advance the ultimate termination of the litigation* since even if the district court reversed the ruling on the Secretary's Motion to Dismiss, there would be two actions: one in the Eastern District of Louisiana and one in the Claims Court. The district court held that the prerequisites for certification pursuant to § 1292(b) had not been satisfied. *See* Minute Entry dated August 5, 1987 attached as Exhibit E.

ISSUES PRESENTED TO THIS COURT

1. Whether a Writ of Mandamus is the appropriate remedy for the Secretary to appeal the district court's denial of the Secretary's Motion for Certification?

2. Whether certification for interlocutory appeal would have been appropriate for the district court's denial of the Secretary's Motion to Dismiss?

STATEMENT OF THE REASONS WHY THE WRIT OF MANDAMUS SHOULD NOT BE ISSUED

1. *Mandamus is Not the Appropriate Remedy for the Secretary*

Writs of mandamus are extraordinary remedies and should be permitted only where an appeal of a final order is clearly inadequate. *Allied Chemical Corp. v. Daiflen,*

449 U.S. 33, 34 (1980); *Banker's Life and Casualty Co. v. Holland*, 346 U.S. 379, 384-85 (1953); *Ex Parte Fahey*, 332 U.S. 258, 256-60 (1947); *U.S. v. Battisti*, 486 F.2d 961, 964 (6th Cir. 1973) (mandamus is appropriate only in extreme or unusual cases); *see also Roche v. Evaporated Milk Ass'n*, 319 U.S. 21, 30 (1943) (inconvenience of going through trial is one which Congress contemplated in providing that only final judgments are reviewable); *Evans Electrical Construction Co. v. McManus*, 338 F.2d 952 (8th Cir. 1964). Use of Mandamus is proper where there is a clear abuse of discretion and where supervisory control of the district courts by the Courts of Appeal is required for proper judicial administration. *See In Re Watkins*, 271 F.2d 771 (5th Cir. 1959) (mere error does not justify mandamus). Courts of Appeal should exercise great discretion in issuing extraordinary writs such as prohibition and mandamus and should exercise such discretion only sparingly. *Hvass v. Graven*, 257 F.2d 1 (8th Cir. 1958), *cert. denied*, 358 U.S. 835 (1959). Moreover, Mandamus should not be treated as an alternative to an appeal and should not be allowed to circumvent appeals which have been barred by Congress. *U.S. v. Hankish*, 462 F.2d 316, 318 (4th Cir. 1972); *Donnelly v. Parker*, 486 F.2d 402, 406 (D.C. Cir. 1973). Even the expense and the inconvenience of a trial does not justify the issuance of mandamus without more. *In Re Estelle*, 516 F.2d 480, 484 (5th Cir. 1975), *cert. denied*, 426 U.S. 925 (1976). As the *Estelle* court clearly noted, mandamus *may not* be used to thwart the congressional policy against piecemeal appeals. *Estelle*, 516 F.2d at 484; *Holland*, 346 U.S. at 382; *Will v. U.S.*, 389 U.S. 90, 104 (1967); *see also*, *In Re Halkin*, 598 F.2d 176 (D.C. Cir. 1979).

Mandamus is not available as a means of reviewing unresolved and difficult questions of law. *State Board of Education v. Fox*, 620 F.2d 578, 579 (6th Cir. 1980). Given the fact that mandamus is a drastic remedy to be

invoked only in extraordinary situations, the parties seeking mandamus must show (1) that no other adequate relief is available *and* (2) that there has been a clear and undisputable judicial usurpation of power or a clear abuse of discretion. *Kerr v. U.S.D.C. for the Northern District of California*, 426 U.S. 394 (1976); *see also, Will*, 389 U.S. at 95; *U.S. v. Dooling*, 406 F.2d 192, 196 (2nd Cir.), *cert. denied*, 395 U.S. 911 (1969); *In Re Vargas*, 723 F.2d 1461, 1467 (10th Cir. 1983), *cert. denied*, 469 U.S. 819 (1984); Mandamus simply does not lie where there is another remedy available. *Spacil v. Crowe*, 489 F.2d 614 (5th Cir. 1974); *Redpaff v. Kissinger*, 415 F.Supp. 566 (D.C. Tex.), *aff'd mem.*, 545 F.2d 167 (5th Cir. 1976).

In its Motion for Certification and in oral argument before the district court the Secretary continually asserted that the Fifth Circuit's decision of the jurisdictional issue would save it time and expense as the Secretary would not have to wait until trial. The Secretary now asserts this in its Writ of Mandamus. However, as noted by this Court in *Estelle*, something more than just expense and inconvenience needs to be shown for Mandamus to be an appropriate remedy. *Estelle*, 516 F.2d at 484. The Secretary has failed to show that there are extraordinary circumstances or that there is a judicial usurpation of power which justifies mandamus. Judge Mentz did not usurp his judicial powers as a district judge since certification of interlocutory appeal is discretionary and is to be granted only in exceptional cases. *Fisions, Ltd. v. U.S.*, 458 F.2d 1241, 1248 (7th Cir.), *cert. denied*, 405 U.S. 1041 (1972). Furthermore, since this Court has taken the position that motions to dismiss are generally not subject to immediate review, Judge Mentz followed this Court and acted within his discretion in denying the Secretary's motion for certification. *See Partrederiat Treasurer Saga v. Joy Manufacturing Co.*, 804 F.2d 308 (5th Cir. 1986); *Catlin v. U.S.*, 324 U.S. 229, 233, 234 (1945).

The district court heard argument on the Motion to Dismiss once and on the Motion for Certification twice. The district court ruled that certification would not advance the ultimate termination of the litigation. The Secretary will be able to address any and all appealable issues upon a final judgment from the district court after trial. Accordingly, this Court should not issue a Writ of Mandamus ordering a reversal of the district court's denial of the Motion for Certification of the Motion to Dismiss as the district court did not abuse its discretion in denying the Secretary's Motion for Certification and as there are other adequate remedies available to the Secretary. In the interest of judicial economy and to avoid multi-forum litigation, the district court denied the Secretary's Motion for Certification and elected to proceed with the trial of this matter. Such a ruling was within the district court's discretion and was in accord with this Court's view of certification for appeal.

2. Certification for Interlocutory Appeal Would Not Be Proper

Plaintiff, the Secretary, asks this Court to certify for an interlocutory appeal its denial of the Secretary's Motion to Dismiss on the jurisdictional issue. The Secretary invokes 28 U.S.C. § 1292(b) as authority for this Court's certification for an interlocutory appeal. Section 1292(b) reads as follows:

> When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a *controlling question of law* as to which there is *substantial ground for difference of opinion* and that an immediate appeal from the order *may materially advance the ultimate termination of the litigation*, he shall so state in writing in such order. The Court of Appeals which would have jurisdiction of an appeal of such action may thereupon, in its discretion,

> permit an appeal to be taken from such order, if application is made to it within ten days after the entry of the order: Provided, however, that application for an appeal hereunder shall not stay proceedings in the district court unless the district judge or the Court of Appeals or a judge thereof shall so order.

In order for a certification to be granted, this Court must find that the district court's order denying the Secretary's Motion to Dismiss met three criteria:

(1) That the order involved a controlling question of law;

(2) That the order concerned an issue for which there is substantial ground for a difference of opinion;

(3) That, if appealed, the ultimate termination of the litigation could be advanced.

See Katz v. Carte Blanche Corp., 496 F.2d 747 (3rd Cir.), *cert. denied*, 419 U.S. 885 (1974). Certification of a legal issue for an interlocutory appeal pursuant to 28 U.S.C. § 1292(b) is discretionary and is to be granted only in exceptional cases. *Fisions*, 458 F.2d at 1248. The discretion has been analogized to that of the Supreme Court's granting certiorari. *Coopers & Lybrand v. Livesay*, 437 U.S. 463 (1978); *Gallimore v. Missouri Pacific Railroad Co.*, 635 F.2d 1165, 1168 n. 4 (5th Cir. 1981). The legislative history of the statute makes clear the strictly discretionary character of the certification determinations by trial and appellate judges. S.Rep. No. 2434, 85th Cong., 2d Sess., *reprinted in* [1958] U.S. Code Cong. & Ad. News 5255, 5257. In the exercise of such discretion, the fact that an issue is a matter of first impression does not in itself meet the prerequisite; there must be some reason to expect that there is some conflicting authority on the issue. *Custanho v. Jackson*

Marine, Inc., 484 F.Supp. 201 (E.D. Tx. 1980), *appeal dismissed in part, order affirmed in part, mandamus denied*, 650 F.2d 546 (5th Cir. 1981). This Court has expressed the view that certification under § 1292(b) should be granted "sparingly, not automatically." *Alabama Labor Council v. Alabama*, 453 F.2d 922, 924 (5th Cir. 1972); *see also Kraus v. Board of County Road Commissioners*, 364 F.2d 919 (6th Cir. 1966) (Congress did not intend to open floodgates to a vast number of appeals from interlocutory orders in ordinary litigation) (citing, *Milbert v. Bison Laboratories*, 260 F.2d 431, 433 (3rd Cir. 1958)).

The criterion under § 1292(b) that there be a "controlling question of law" is not to be approached in terms of what is convenient to the parties. *See Garner v. Wolfinburger*, 433 F.2d 117, 120 (5th Cir. 1970). Such an approach would foster piecemeal appeals, which are contrary to the policy and language of § 1292(b). This Court has taken the position that motions to dismiss are generally not subject to immediate review. *Partrederiet Treasure Saga v. Joy Manufacturing Co.*, 804 F.2d 308 (5th Cir. 1986) (considering an appeal under 28 U.S.C. § 1291); *see also Catlin v. United States*, 324 U.S. 229, 233-234 (1945) (policy of requiring reviews of only final decisions is to avoid piecemeal litigation which leaves only fragments of a case for final resolution). Thus, this Court should require certification of the district court's denial of the Secretary's Motion to Dismiss only if the three criteria of § 1292(b) are met and only if immediate appeal from the order would advance the ultimate termination of this litigation. Here, a certification would not achieve the goals of § 1292. The determination of the jurisdictional issue would not advance the ultimate termination of this litigation. If anything, it would turn the litigation into complex, multi-court litigation and would prolong the former employees suit against Pan American Life Insurance Company

("PALIC") and the Pan American Life Insurance Company Employees Retirement Plan ("PALIC Retirement Plan") and would make the former employees suit against PALIC and the PALIC Retirement Plan unaffordable. It would therefore not be in the interest of justice or judicial economy to require certification of the district court's denial.

A. *No Controlling Question of Law*

The issue presented to the district court for certification was not a novel question of law over which differing views existed. This matter is a private action by plaintiffs, Joseph Morales, David Winters, Barkef K. Osigian, Camille Hubble and Ben F. McKown and a class of nonvested PALIC employees certified by the district court, against defendants, PALIC and the PALIC Retirement Plan. This *dispute is not* a lawsuit against the United States Government. Presently, without the issuance of a final decision, there is not even a dispute between PALIC and the Secretary. As a result, the Claims Court lacks jurisdiction to try this dispute. *Transcounty Packing Co. v. United States*, 568 F.2d 1333, 215 Ct. Cl. 390 (Ct. Cl. 1978) (The Claims Court is a court of limited statutory jurisdiction which cannot be expanded beyond bounds established by Congress).

There is no "controlling question of law" since there is no real question at all.[2] The Claims Court only has jurisdiction to hear claims *against* the government. *Bogart v. U.S.*, 557 F.2d 237, 214 Ct. Cl. 332 (1977); *See* 28 U.S.C. § 1491(a)(1). Consequently, as there is no suit by anyone in this matter against the United States Government, the Claims Court lacks jurisdiction.

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[2] Claims such as those in this action based on a theories of unjust enrichment and third-party beneficiaries are beyond the jurisdiction of the Claims Court. *Dwlyer v. United States*, 7 Cl. Ct. 622 (1985); *Penn. Towne Builders, Inc. v. United States*, 4 Cl. Ct. 677 (1984); *Public Service Co. v. United States*, 5 Cl. Ct. 818 (1984).

The Secretary would have this Court believe that the Contract Disputes Act of 1978 ("CDA") establishes exclusive jurisdiction within the Claims Court for its potential dispute with PALIC regarding a contractual relationship beginning in 1966. However, a close examination of the CDA reveals otherwise. CDA was enacted by Congress in 1978. Pub. L. 95-563, Nov. 1, 1978. Section 16 of Pub. L. 95-563 provided the effective date of the Act:

> This Act shall apply to contracts entered into one hundred and twenty days after the date of enactment [Nov. 1, 1978]. Notwithstanding any provision in a contract made before the effective date of this Act, *the contractor may elect* to proceed under this Act with respect to any claim pending then before the contracting officer or initiated thereafter. (Emphasis added).

Pub. L. 95-563 § 16; 41 U.S.C. § 601 (annotations).

Here, the Medicare Contract was originally entered into between PALIC and the Secretary in July of 1966. The contract was for a term of twenty years; however, in December of 1984, the Secretary terminated the Medicare Contract. The contract entered into by PALIC and the Secretary in 1966 was renewed several times prior to the cancellation in 1984.[3] The Secretary would like the district court as well as this Court to believe that the CDA applies retroactively. However, such is not the case. Section 16 specifically states that the Act shall

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[3] The Secretary has asserted that the renewal contract entered into in 1980 and the provisions of that contract govern the entire contractual relationship since 1966. However, as evidenced by another renewal contract, provided by defendants to the district court on July 29, 1987 and attached as Exhibit F, disputes could be resolved in any court of competent jurisdiction. Defendants submit that at the time of that renewal contract and of earlier contracts in existence prior to the CDA, the district court had jurisdiction to hear such a dispute.

apply to contracts entered into 120 days after the date of enactment: November 1, 1978. As § 16 of the CDA provides only an option for a contractor to proceed under the Act, the Secretary may not correctly assert that the Act retroactively applies and may not elect to make any contracts written prior to the CDA subject to the CDA's provisions.

Contrary to the Secretary's assertions, the Claims Court does not have exclusive jurisdiction of any potential dispute between PALIC and the Secretary regarding over-funding since the majority of the Medicare contract between PALIC and the Secretary was executed before the effective date of the CDA. According to the CDA, the contractor, here PALIC, *may elect* to proceed under the CDA of 1978; a contractor made party to a contract before the effectiveness of the CDA is not compelled to choose the CDA. *See, e.g., Vista Scientific Corp. v. United States*, 808 F.2d 50 (Fed. Cir. 1986); *S.E.R. Jobs for Progress, Inc. v. United States*, 759 F.2d 1 (Fed. Cir. 1985).

Even if the Secretary is correct (which PALIC and the PALIC Retirement Plan vehemently deny) and a portion of the contract is subject to the CDA, only four years out of the eighteen years of the overall contract can be subject to the CDA. As a result, the majority of the contract is within the discretion of the district court which is able to exercise jurisdiction over any small part of the contract which could be heard by the Claims Court in order to avoid multi-forum litigation. *See infra* at fn. 5.

Section 14(a) of CDA repealed Section 1346(a)(2) of Title 28 of the United States Code by taking jurisdiction of any civil action or claim *against* the United States founded upon any express contract with the United States from the district courts. However, jurisdiction of other claims relating to contracts with the United States Government was not taken from the District Courts.

Here, there is no claim against the U.S. Government. The money is held by PALIC and the PALIC Retirement Fund. The claims are being made *by* the *former PALIC employees*, PALIC Retirement Plan participants *and the Government against PALIC*. Accordingly, the district court has jurisdiction of the Secretary's claim against PALIC.

As plaintiff former employees correctly pointed out in their Memorandum in Opposition to the Secretary's Motion to Dismiss at page 4:

> The distinction which is important is that this involves a claim *by* the United States, namely, HHS against Pan-American Life, and possibly a claim by HHS against plaintiffs, if plaintiffs succeed against Pan-American Life. 28 U.S.C. § 1345 specifically permits and grants original jurisdiction to the United States District Courts when the United States Government is a plaintiff.

See Opposition Memorandum filed by former PALIC employees at p. 4, attached as Exhibit E.

Furthermore, 28 U.S.C. § 1346(2)(c) specifically provides that where the United States Government is a defendant, the jurisdiction of the district court includes the jurisdiction of any other claim or demand on the part of the United States. *See* 28 U.S.C. § 1346(2)(c).

Here, the government has been determined to be a necessary party plaintiff. The Secretary has made a claim against PALIC and the PALIC Retirement Plan for the same funds against which the former PALIC employees have made claims. The district court has jurisdiction to hear both of these claims: one by former PALIC employees and one by the Secretary *against* PALIC and the PALIC Retirement Plan.[4]

[4] It must be noted that all of the Secretary's cited authority for its assertion of exclusive jurisdiction involve the United States

B. *There are No Grounds on Which Opinions Could Differ*

Section 1491(a)(1) of Title 28 clearly states that the Claims Court should have jurisdiction upon any claim *against* the United States. 28 U.S.C. § 1491(a)(1). To fulfill the second criterion of certification for interlocutory appeal, there must be some difference of opinion as to the pertinent issue of law. Interlocutory appeals are not proper for disputes over issues of fact. *Clark-Dietz & Assocs.-Engrs. v. Basic Construction, Co.*, 702 F.2d 67, 69 (5th Cir. 1983). While the Secretary may want to argue that there are issues of law over which opinions could differ, the Secretary fails to see or even to show to this Court an actual claim against the government. There is no question that in a claim against the government, the Claims Court has jurisdiction. However, the question before this Court is whether there is a claim against the government. As of the date of this Opposition, there is no claim against the government. As a result, there is no question of law over which opinions could differ. At the least, there are presently only questions of fact.

Issues Of Fact Exist Precluding Certification

The Secretary apparently contends that the contract entered into in 1980 governs the entire relationship between PALIC and the Secretary. However, this assertion ignores the facts that PALIC and the Secretary have had a contractual relationship since 1966 governed by a prior agreement or agreements and that the 1980 agreement was for a one year term and was extended until December 31, 1984. Further, the audit covers the time period of 1966 until the date of termination. Thus, more

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as a defendant against whom a claim has been made. Such is not the situation in this dispute. Moreover, none of the cases cited by the Secretary involve an audit by the Department of Health & Human Services of a Medicare Contract.

than one agreement possibly governs the relationship between PALIC and the Secretary and any disputes arising under that 18-year relationship. As a result, the terms of the 1980 agreement alone are not dispositive.

The existence of these factual issues further precludes certification because factual issues are not proper for certification of an interlocutory appeal. *Louisiana Ice Cream Distributors, Inc. v. Carvel Corporation and Franchise Stores Realty Corp.*, No. 86-3601, slip op. (5th Cir. June 30, 1987) (*see* attached Exhibit B); *see also, Paragon Resources, Inc. v. National Fuel Gas Distribution Corp.*, 695 F.2d 991 (5th Cir. 1983); *Johnson v. Alldredge*, 488 F.2d 820, 822 (3rd Cir. 1973), *cert. den.*, 419 U.S. 882 (1973). The Secretary's attempt for an interlocutory appeal is improper and would serve only to waste the time of both this Court and the district court.

C. *An Appeal Would Not Advance the Ultimate Termination of the Overall Dispute*

In an attempt to avoid the district court's jurisdiction of the Secretary's claim against PALIC and the PALIC Retirement Fund, the Secretary argued that a dispute between PALIC and the Secretary relating to the Medicare Contract would arise after the final audit. What the Secretary failed to point out is that even if such a dispute does arise and PALIC has a claim against the United States, the contractor, here PALIC, under the CDA of 1978, has the option because of the date on which the contract was entered. PALIC need not make that election now and depending upon the final audit may not ever need to make such an election. Presently, there is no claim against the Government. The Government has a claim against PALIC. Thus, the district court has jurisdiction over the Government's claim against PALIC, a claim which is so closely related to the former PALIC

employee's claims, that to sever the two claims would lead to a multiplicity of complex litigation.

The Secretary fails to realize that *its presence is vital* to the determination of the issues in this lawsuit because the Secretary itself claims that it is entitled to the same funds to which the former employee plaintiffs' claim. Furthermore, the claims against PALIC and the PALIC Retirement Plan must be heard by the district court as the Claims Court lacks jurisdiction over claims between private parties and over the quasi-contractual claims of the participant plaintiffs contained in their Complaint. *See H. F. Allen Orchards v. United States*, 749 F.2d 1571 (Fed. Cir. 1984), *cert. denied*, 88 L. Ed. 2d 52, 106 S.Ct. 64 (1985); *Public Service Co. v. United States*, 5 Cl. Ct. 818 (1984); *Penn. Towne Builders, Inc.*, 4 Cl. Ct. 677 (1984). The Claims Court has no power to hear equitable or quasi-contractual claims. *See Penn. Towne*, 4 Cl. Ct. at 682; *Merritt v. United States*, 267 U.S. 338, 341 (1925). Thus, even assuming that the Secretary is correct and any dispute between PALIC and the Secretary would eventually be in the Claims Court, that Court would be unable to hear the other claims in this action. Thus, the Secretary's proposed resolution of these issues would lead to a multiplicity of actions in two separate federal courts. This would be a waste of judicial time and expense and would contravene the purpose of interlocutory appeals.[5] As correctly noted by Judge Mentz in his Minute Entry:

> [A]n immediate appeal from this Court's ruling that it has jurisdiction over Dept. of Health & Hu-

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[5] The purpose of interlocutory appeals pursuant to 28 U.S.C. § 1292(b) is to avoid protracted and expensive litigation, not to create it. *See Lear Siegler, Inc. v. Adkins*, 330 F.2d 595, 598 (9th Cir. 1964); *See also Paschall v. Kansas City Star Co.*, 605 F.2d 403, 406 (8th Cir. 1979), *rev'd on other grounds*, 727 F.2d 692 (8th Cir. 1984), *cert. denied*, 469 U.S. 872 (1984); Wright, *Law of Federal Courts* § 102 (1983).

> man Services' claim will not materially advance the ultimate termination of the litigation inasmuch as a reversal of this Court's ruling will result in two suits—one in the Eastern District of Louisiana, and one in the Court of Claims. Thus, the prerequisites for certification pursuant to 28 U.S.C. § 1292(b) have not been met.

Minute Entry, Exhibit E.

It has long been the policy of the United States Supreme Court that the use of interlocutory appeals should not result in piecemeal litigation. *See Catlin v. United States*, 324 U.S. 229, 233-234 (1945). Moreover, in a recent United States Court of Appeals decision, it was noted that it is well-settled law that a party may not take an interlocutory appeal from the denial of its motion to dismiss for lack of subject matter jurisdiction. *In Re United States Catholic Conference*, No. 86-6092, slip op. at 8 (2nd Cir. June 4, 1987) (*see* attached Exhibit F); *see also Catlin*, 324 U.S. at 233; *Partrederiet Treasure Saga v. Joy Manufacturing Co.*, 804 F.2d 308 (5th Cir. 1986).

Given the complex, multi-party, multi-claim nature of this dispute, the most efficient manner in which to resolve the dispute will be to have all parties in one Court. If the Secretary proceeded in the Claims Court while plaintiffs remained in this Court, PALIC would potentially be subject to either conflicting or multiple judgments (the Claims Court has no jurisdiction to try plaintiffs' claim). The ultimate end of the litigation would thus not be advanced as two actions, rather than one, would result. Such a situation is contrary to the policy of 28 U.S.C. § 1292 and would result in a waste of judicial energy and time.

All claims however can be heard by the district court. In the interest of avoiding multiplicity of actions and in order to most effectively dispose of all the claims against

PALIC and the PALIC Retirement Plan for the funds held by the Plan, the district court could exercise pendant jurisdiction over any claims PALIC may have as a result of the final audit against the Secretary. *See Woodland Nursing Home Corp. v. Califano*, 487 F.Supp. 9 (S.D. N.Y. 1979).[6]

The district court has jurisdiction as this is not a claim *against* the Government. Any dispute that may arise between PALIC and the Secretary will arise out of a contractual relationship that originated in 1966 and an audit of certain practices under that relationship. The Claims Court does not have exclusive jurisdiction over such a possible dispute. If anything, it only has jurisdiction over a small time frame of the contractual relationship: October 1980 through December 1984. No provision of the 1980 contract provides that the prior contract or contracts are subject to the CDA. Accordingly, the district court has jurisdiction of the matter as the Claims Court does not have exclusive jurisdiction over the contractual relationship.

Finally, even assuming the Claims Court has exclusive jurisdiction over the October 1980 through December 1984 contract, it is in the interest of judicial economy that the district court exercise *pendant jurisdiction* over any minute portion to avoid complex and expensive multi-forum litigation.

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[6] Although pendant jurisdiction is ordinarily used to give a federal court jurisdiction over state claims related to a federal claim properly before the court, pendant jurisdiction has also been used to give the federal court jurisdiction over another federal claim not otherwise properly before the court. *See Hagans v. Lavine*, 415 U.S. 528, 94 S.Ct. 1372, 39 L.Ed. 2d 577 (1974); *Morrow v. Dist. of Columbia*, 417 F.2d 728, 738 (D.C. Cir. 1969); *Woodland Nursing Home Corp. v. Califano*, 487 F.Supp. 9 (S.D. N.Y. 1979).

CONCLUSION

There was no reason to grant the Government's Motion to Dismiss and there was no reason to certify the dismissal; moreover, there will be no reason to transfer any dispute which may arise between PALIC and the Government to the Claims Court. The ultimate termination of this litigation will not be advanced by certification of the district court's denial of the Secretary's Motion to Dismiss. Thus, this Court should refuse to grant the Secretary's Writ of Mandamus.

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing has been served upon all counsel of record by depositing same in the United States Mail, postage prepaid and properly addressed, this 2nd day of September, 1987.

/s/ Dermot S. McGlinchey
DERMOT S. MCGLINCHEY

APPENDIX J

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Civil Action No. 85-3323

SECT. I MAG. 1

JOSEPH V. MORALES, *et al.*,
Plaintiffs,

v.

PAN-AMERICAN LIFE INSURANCE COMPANY, *et al.*,
Defendants.

[Filed Jan. 20, 1987]

SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES'S MOTION TO APPEAR AS AMICUS CURIAE

The Secretary of the Department of Health and Human Services (HHS) respectfully moves the Court to allow HHS to appear as *amicus curiae* in this case. In support of this motion, HHS relies upon the attached memorandum.

Respectfully submitted,

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Assistant Attorney General
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JOHN VOLZ
United States Attorney
Eastern District of Louisiana

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

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SECT. I MAG. 1

JOSEPH V. MORALES, *et al.*,
Plaintiffs,

v.

PAN-AMERICAN LIFE INSURANCE COMPANY, *et al.*,
Defendants.

MEMORANDUM IN SUPPORT OF MOTION TO APPEAR AS AMICUS CURIAE

We established in our motion to dismiss filed concurrently with this motion that HHS does not have a claim against Pan-American Life Insurance Company within the jurisdiction of this Court. HHS does have, however, an interest in this litigation.

By this action, plaintiffs seek "an allocation of assets among the participants and beneficiaries" of the pension plan into which HHS paid under its agreement with Pan-American for administration of the Medicare Program in Louisiana. Amended Complaint-Class Action ¶ 32. As plaintiffs acknowledge in their amended complaint, it remains unsettled at this time whether HHS overpaid Pan-American for pension costs under this agreement. *Id.* at ¶ 54. At the same time, plaintiffs allege:

> The amount of the contribution to the plan is exactly delineated because the government, under the Medicare contract, contributed all of the funds for these participants into the pension plan. Therefore, an exact dollar amount of the contributions is available for the terminated portion of the plan.

Id. at ¶ 33. Obviously, if it is unsettled whether HHS overpaid Pan-American, it cannot also be that "[t]he amount of the contribution to the plan is exactly delineated . . . ."

If this Court were to distribute to the plaintiffs in this case and those similarly situated assets paid as pension costs under the agreement between HHS and Pan-American, it might be that Pan-American would later be required to pay again, to return to HHS the amounts overpaid under the agreement. Alternatively, even if HHS overpaid Pan-American for pension costs under the agreement, any amounts distributed by this Court might, by virtue of that circumstance alone, be deemed reasonable and allowable costs recoverable by Pan-American under its agreement with the Government.

In short, HHS has an interest in the amounts which are the subject of this litigation. Moreover, HHS's interests are not adequately represented by the plaintiffs or by Pan-American. It is HHS's interest to reduce the amount for distribution to plaintiffs and to recover that money itself from Pan-American.

In light of the possibilities discussed above, HHS requests that its motion to appear in this litigation as *amicus curiae* be granted. HHS further requests that the Court file, consider, and grant the attached motion to stay proceedings regarding damages in this case to allow the question of the proper amount of pension costs pay-

able under the agreement between HHS and Pan-American be determined in an appropriate forum.

Respectfully submitted,

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Assistant Attorney General
Civil Division

JOHN VOLZ
United States Attorney
Eastern District of Louisiana

/s/ Joan Elaine Chauvin
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APPENDIX K

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

(Agreement with Carrier Pursuant to Section 1842 of the Social Security Act, as Amended)

Agreement No. HCFA 78-313-2

AGREEMENT

Between

The Secretary of Health, Education, and Welfare

and

Pan-American Life Insurance Company

(To carry out the provisions of section 1842 of the Social Security Act, as amended)

The Secretary of Health, Education, and Welfare, hereinafter referred to as the Secretary, and Pan-American Life Insurance Company, hereinafter referred to as the Carrier, for the purposes of carrying out the provisions of section 1842 of the Social Security Act, as amended (providing for the use of Carriers to administer Part B of Title XVIII of the Social Security Act, as amended) hereby agree to the following terms:

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Article I

DEFINITIONS AND DELEGATIONS

For the purposes of this agreement:

A. The term "Secretary" means the Secretary of Health, Education, and Welfare or his delegate, unless otherwise specified.

B. The term "Act" means the Social Security Act, as amended.

C. The term "eligible individual" means an individual entitled to have payment made under part B of Title XVIII of the Act for covered services furnished such individual.

D. The term "services" means items or services (other than items or services listed in section 1862 of the Act) for which an eligible individual may be entitled to have payment made under section 1832(a)(1) of the Act.

E. The term "General Instructions" means manuals and other written instructions of general application to fiscal Intermediaries or Carriers issued by the Secretary pursuant to the Act in respect to matters covered by this agreement.

F. The term "Regulations," unless otherwise specified, means those regulations promulgated by the Secretary pursuant to the Act and codified in the Code of Federal Regulations, Title 42, Parts 400ff.

G. The term "subcontract" means any contract, agreement, purchase order, or lease (including leases of real property) to obtain space, supplies, equipment, or services under this agreement; the term "subcontractor" means any holder of one or more subcontracts.

H. The term "Federal Procurement Regulations (FPR)," as used in this agreement, means those Parts of the Federal Procurement Regulations to which reference is made hereinafter, as in effect on July 1, 1978,

codified in the Code of Federal Regulations, Public Contracts and Property Management, Title 41, Chapter I.

I. The term "Carrier" means the contractor which is a party to this agreement pursuant to section 1842 of the Act, as amended.

J. Responsibility for the administration of this agreement has been delegated by the Secretary to the Administrator of the Health Care Financing Administration, (HCFA) and has been further redelegated to the Deputy Administrator of HCFA and to the Director of the Medicare Bureau. Concerning the authorization to administer matters covered under this agreement, any written statement with respect to matters covered by this agreement by (1) such Administrator, Deputy Administrator, or Director of the Medicare Bureau; or (2) the Regional Medicare Director and such other positions as such Administrator authorizes (but only with respect to matters specifically covered by such authorization) shall have the same force and effect as though issued by the Secretary. With respect to the positions designated in clause (2) of the preceding sentence, the Director of the Medicare Bureau shall furnish the Carrier a list of such positions and the matters with respect to which they are authorized to act.

Article II

FUNCTIONS TO BE PERFORMED BY THE CARRIER

The Carrier shall:

A. Receive, disburse, and account for funds in making payments for services furnished to eligible individuals within the jurisdiction of the Carrier pursuant to Articles VII, VIII, and IX.

B. Make determinations as to the coverage of services and make payments determined to be due for services furnished to eligible individuals pursuant to Article VII.

C. Determine the reasonable charges with respect to services furnished to any eligible individual pursuant to Article V.

D. Institute utilization safeguards which include methods for professionally assuring that payments made under Part B are for covered services which are medically necessary pursuant to Article XIII B.

E. Establish methods and procedures for identifying utilization patterns which deviate from medically established norms, and bring such patterns of utilization to the attention of appropriate professional groups pursuant to Article XIII A.

F. Furnish to the Secretary such timely information and reports as the Secretary may find necessary pursuant to Article XI.

G. Establish and maintain procedures whereby an individual enrolled under Part B will be granted an opportunity for a fair hearing pursuant to Article XII.

H. Maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information necessary for the administration of this agreement.

I. Upon inquiry, assist individuals with respect to matters pertaining to this agreement.

J. Assist any institution, facility or agency to qualify as a provider of services and to furnish consultative services to such provider to enable it to establish and maintain fiscal records for purposes of Title XVIII of the Act. Consultative services by the Carrier or any parent, affiliated or subsidiary organization, for providers of services, shall not include (1) the preparation or completion of preliminary or initial cost reports, or (2) the compilation and maintenance of statistical or financial data and records.

K. Serve as a channel of communication to and from the Secretary of such information, instructions, and other material as may be necessary for the effective and efficient performance of this agreement.

L. Undertake to adjust underpayments and recover overpayments pursuant to Article VII when it has been determined that an incorrect payment has been made.

M. Perform such other functions as shall be mutually agreed upon by the Secretary and the Carrier as necessary to carry out the purposes of this agreement.

Article III

FUNCTIONS TO BE PERFORMED BY THE SECRETARY

The Secretary shall:

A. Provide funds to the Carrier for making payments to providers of services and eligible individuals and for the Carrier's cost of administering this agreement pursuant to Articles VIII and IX.

B. Afford the Carrier an opportunity to consult with the Secretary pursuant to Article X B.

C. Maintain a master record of eligibility and claims history of individuals entitled to services and, upon inquiry by the Carrier, furnish it the names and other information pertinent to the administration of this agreement with respect to such individuals and of their eligibility to have payment made for services furnished them pursuant to Article VII.

D. Furnish the Carrier such information as may be necessary to determine (1) whether an individual who has been furnished services is an eligible individual and (2) the extent to which the deductibles, specified in section 1833(b) of the Act, have been met by such individual or the extent to which other provisions of Title

XVIII of the Act affecting payment are involved (including, but not limited to, sections 1833(c) and (d) of the Act) in determining the payments due such individual under such title.

Article IV

JURISDICTION

A. The Carrier shall perform the functions under this agreement for Louisiana and, as the Secretary may designate, for Part B payments for services rendered outside of the United States pursuant to section 1814f of the Act, except with respect to individuals who are railroad employees or are entitled to receive annuities or pensions under the Railroad Retirement Act of 1937 and except with respect to:

(1) Any group of eligible individuals under a plan of any State (referred to above) approved under Title I, IV, X, XIV, or XIX of the Act where an agency of such State has, through an agreement entered into with the Secretary under section 1843(f) of the Act, been designated as a Carrier to administer Part B of Title XVIII of the Act with respect to such eligible individuals, or

(2) any group of eligible individuals enrolled in a group practice prepayment plan which has been determined by the Secretary to be eligible to deal directly with HCFA, or

(3) requests for payments under such Part B from any class or classes of eligible individuals in the State or States or portions thereof (referred to above) with respect to which the Secretary has, prior to the date this agreement is executed, notified the Carrier in writing that Part B of Title XVIII of the Act can be administered with maximum efficiency and convenience for such class or classes of eligible individuals in a manner other than an agreement pursuant to section 1842 of the Act, or

(4) requests for payments under such Part B from any class or classes of eligible individuals in the State or States (referred to above) in addition to any group referred to in subparagraph (1) above, and not including any group of individuals referred to in subparagraphs (2) and (3) above, which the Secretary and the Carrier mutually agree, after the effective date of this agreement, to exclude from the jurisdiction of this agreement, or

(5) requests for payments under such Part B from any group of individuals receiving services from a free-standing, federally funded health center which receives funds under (i) section 319 or 330 (A) of the Public Health Service Act or (ii) Title II of the Community Mental Health Center Act of 1975 or (iii) the Appalachian Regional Development Act or (iv) any other federally administered programs for health services delivery, and which, as determined by the Secretary, qualifies for and elects to receive payments directly through HCFA, or

(6) any group of eligible individuals enrolled in or receiving services from a Health Maintenance Organization approved by the Secretary for participation under Title XVIII of the Act.

B. Except with respect to any group of individuals referred to in paragraph A(2) of this Article, the Secretary shall notify the Carrier in writing not less than 90 days prior to the date on which he proposes to take action, the effect of which is to include within the jurisdiction of this agreement any group of eligible individuals referred to in paragraph A(1) of this Article, or to exclude from, or to include within, the jurisdiction of this agreement any other group of eligible individuals or any class or classes of eligible individuals. Both the Secretary and the Carrier shall make provisions for any orderly transfer of such group of eligible individuals or

such class or classes of eligible individuals so that they are excluded from, or included within, the jurisdiction of this agreement.

C. The Secretary shall also notify the Carrier in writing 90 days prior to the date on which the Secretary proposes to take action when (1) action is to be taken pursuant to which (i) any group of individuals (as described in paragraph A(1) of this Article) in the State or States (referred to in such paragraph A) is enrolled under section 1843(a) of the Act or (ii) the enrollment of such group under such Part B is terminated, or (2) any action is to be taken pursuant to which any group of individuals referred to in paragraph A(2) of this Article is excluded from the jurisdiction of this agreement.

Article V

DETERMINATIONS BY THE CARRIER

A. The Carrier shall determine reasonable charges with respect to services to any eligible individual furnished within the jurisdiction of the Carrier, as specified in Article IV. In determining the reasonable charge for such services, the Carrier shall take into consideration the customary charges for similar services generally made by the physician or other person furnishing such services as well as the prevailing charges in the locality for similar services. In addition, the Carrier shall take such action as may be necessary to assure that such charges are not higher than the charge applicable for services furnished policyholders and subscribers of the Carrier where such latter services are comparable to such services and are furnished under comparable circumstances.

B. In carrying out the functions specified in the preceding paragraph, the Carrier shall to the extent that is practical:

(1) consult with, and take into consideration, the advice of State and local organizations of physicians and, as appropriate, other organizations in the health field, and

(2) utilize such societies and associations or other groups to provide advice and assistance in cases where eligible individuals, physicians, or other persons furnishing services disagree with the Carrier's determinations pursuant to this Article.

C. Subject only to the fair hearing procedure provided under Article XII, any determination of reasonable charges made by the Carrier in accordance with this agreement shall be conclusive for the purpose of determining the amount of payments which are required to be made to, or on behalf of, any eligible individual under this agreement.

Article VI

EXCHANGE OF INFORMATION BETWEEN SECRETARY AND CARRIER

The Secretary and the Carrier shall exchange with, and make available to each other, sufficient information so that this agreement is administered with maximum efficiency and effectiveness.

Article VII

PAYMENTS TO OR ON BEHALF OF ELIGIBLE INDIVIDUALS

A. The Carrier shall make determinations as to the coverage of services in accordance with the Act, Regulations and General Instructions and make payments determined to be due (pursuant to the provisions of section 1833 of the Act) for services furnished to eligible individuals, in accordance with determinations made pur-

suant to Article V of this agreement, except that no such payment shall be made unless:

(1) there is furnished to the Carrier by or on behalf of the eligible individual, an itemized bill or

(2) there has been an assignment by an eligible individual to the person furnishing such services under the terms of which the amount determined by the Carrier to be a reasonable charge (pursuant to Article V of this agreement) is the full charge for the services furnished. Such payments shall be made with such frequency as the Carrier deems appropriate; however, such payments should be made within one month after payment has been determined to be due and the appropriate payee has been established. The Carrier shall use its best effort to process claims and make payments as expeditiously as possible.

B. The Carrier shall make payments determined to be due to outpatient physical therapy providers of service for covered services in accordance with provisions of the Act, Regulations and General Instructions promulgated by the Secretary.

C. If, after payment has been made to, or on behalf of, an eligible individual, it is determined that more or less than the correct amount has been paid by the Carrier, the Carrier shall undertake to adjust the underpayment or recover the overpayment except that the Carrier shall not initiate court proceedings to recover any overpayment. If, within such period as may be specified in Regulations or General Instructions the Carrier is unable to adjust the underpayment or recover the overpayment, the Carrier shall so notify the Secretary after such period has expired.

D. No individual designated as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any

payment certified by him pursuant to this agreement. No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments made by him under this agreement if it was based upon a voucher signed by a designated certifying officer. The Carrier shall not be liable to the United States for payments referred to in the two preceding sentences.

E. No certifying officer or disbursing officer shall be held liable for any amount certified or paid by him under this agreement where adjustment or recovery of such amount (as authorized by section 1870 of the Act) is waived pursuant to such section 1870(c) or where adjustment authorized under section 1870(b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

Article VIII

ADVANCE OF FUNDS THROUGH LETTER OF CREDIT

A. The Secretary shall provide for an advance of funds by a letter of credit to the Carrier's commercial bank to authorize the withdrawal of funds from the United States Treasury and a transfer of such funds to the Federal Health Insurance Benefits Account established in accordance with Article IX. Each letter of credit will authorize the Carrier's commercial bank to process payment vouchers to be presented to the Federal Reserve Bank for credit to the Federal Health Insurance Benefits Account. (This method of letter of credit financing is referred to as "checks paid.") The bank will be authorized to process payment vouchers, drawing on the Social Security Trust Funds through a Federal Reserve Bank. The Secretary may provide for advance of funds through a letter of credit and for the processing of pay-

ment vouchers by the carrier until the checks paid method is implemented.

B. Funds withdrawn and transferred as described in the preceding paragraph shall be used only:

(1) to provide funds for payment to, or on behalf of, eligible individuals as specified in Article VII,

(2) to provide funds for the administration of this agreement, as specified in Article XVII,

(3) to establish and maintain the Federal Health Insurance Time Account.

C. The letter of credit will specify a maximum monthly amount which may be withdrawn during each month based on estimates by the Secretary of the amounts needed to make such payments. Amounts available for withdrawal but not withdrawn in any month will not carry over to the following month. However, the Carrier or bank shall make withdrawals only to the extent that funds are needed to meet current payments and expenditures under paragraph B. If the amount specified in the letter of credit is not sufficient to meet current payments and expenditures under paragraph B of this Article, the letter of credit shall be revised promptly by the Secretary.

Article IX

TRANSFER OF FUNDS WITHDRAWN INTO A FEDERAL HEALTH INSURANCE BENEFITS ACCOUNT

A. All funds withdrawn through the letter of credit, as specified in Article VIII shall be designated for deposit only in a Federal Health Insurance Benefits Account of a member bank or banks of the Federal Reserve System or any insured bank within the meaning of the Act creating the Federal Deposit Insurance Corporation (Act of August 23, 1935, 49 Stat. 648), as amended (12

U.S.C. 264) and be kept separate and apart from the Carrier's general or other funds. The Carrier is also authorized to establish a Federal Health Insurance Time Account in conjunction with this agreement. Both the Federal Health Insurance Benefits Account and the Federal Health Insurance Time Account shall be so designated as to indicate clearly to the bank the special character and purpose of such funds. The funds from the Federal Health Insurance Benefits Account shall be used by the Carrier exclusively for making payment of benefits, administrative costs, and the funding of a Federal Health Insurance Time Account where established. The Carrier shall submit monthly statements to the Secretary showing the disbursements made from such Federal Health Insurance Benefits Account.

B. The Carrier shall furnish to the Secretary copies of the agreement(s) executed with each bank in which the Federal Health Insurance Benefits Account or the Federal Health Insurance Time Account is established. Such agreement shall be executed on forms prescribed by the Secretary and shall contain a provision that the United States shall have a lien upon the credit balance in such Federal Health Insurance Benefits Account or Federal Health Insurance Time Account to secure repayment of all funds advanced under this agreement. Such lien shall be superior to any lien or claim of the bank with respect to such accounts. In the interest of effective and efficient administration of this agreement the Secretary may, after consultation with the Carrier, direct the Carrier in writing to cause termination of the agreement(s) with the bank after 150 days written notification prior to the expiration of the current term when the checks paid method is used (120 days written notification if checks paid method is not in effect) and to have established the Federal Health Insurance Benefits Account and the Federal Health Insurance Time Account when the checks paid method is used, in another bank

meeting the standards referred to in paragraph A of this Article. The letter of credit method of financing in accordance with Department of the Treasury, Circular No. 1075 (fourth revision), 1973, Section 2055.20, will be implemented.

Article X

COMPLIANCE WITH REGULATIONS AND GENERAL INSTRUCTIONS

A. The Carrier shall comply with such Regulations and General Instructions as the Secretary may from time to time prescribe for the administration of this agreement.

B. In the course of the development of such Regulations and General Instructions for the administration of this agreement, and prior to the issuance thereof, the Secretary shall provide adequate prior notice to the Carrier and afford prior consultation with a representative group or groups of Carriers with which agreements have been executed pursuant to section 1842 of the Act, with respect to the content of such Regulations or General Instructions and their effect upon the administration of this agreement; provided, however, the Regulations or General Instructions may be issued without prior consultation if deemed necessary by the Secretary.

C. The Carrier shall not be deemed to be in default of its obligations under this agreement, if, for a reasonable length of time, but in no event less than 90 days, it fails to implement any Regulation or General Instruction due primarily to the lack of then available funds, personnel, or equipment necessary to perform the activities required under the Regulation or General Instruction.

D. If the Carrier finds that compliance by it with any Regulation or General Instruction prescribed by the Sec-

retary, after the effective date of this agreement, for the administration of this agreement, is in conflict with any requirement or obligation to which the Carrier is subject in the conduct of its principal business activities or is in conflict with the policies and principles established by the Carrier for the conduct of its principal business activities, the Carrier may, notwithstanding any provision of this agreement to the contrary, terminate this agreement, after giving notice to the Secretary of its intention to terminate this agreement and the reasons therefor. Such termination shall become effective no earlier than 6 months after the date of such notice unless the parties agree to an earlier date.

Article XI

ACCUMULATION AND DISSEMINATION OF INFORMATION

A. The Carrier shall, at the request or on the approval of the Secretary, engage or participate in statistical and research studies pertinent to the program under Part B of Title XVIII of the Act as the Secretary deems necessary.

B. The Carrier agrees that the Secretary shall, at such times and in such manner as he may prescribe, have access to any data acquired or utilized by it in the development and processing of claims or in carrying out its other functions under this agreement, and, further, shall have use of such data (other than discrete data, such as trade secrets, commercial or financial data obtained solely from the private business of the Carrier and Information described in paragraph C of this Article). The Carrier shall also, at such times and in such manner as the Secretary may prescribe, furnish to other organizations for use in administering health care or health care financing programs under the Act data acquired or utilized by it in the development and process-

ing of claims or other data (other than discrete data, such as trade secrets, commercial or financial data obtained solely from the private business of the Carrier and Information described in paragraph C of this Article) acquired by it in carrying out its functions under this agreement.

C. For purposes of this Article, the term "Information" shall mean all systems documentation, program logic, operating manuals, and all other operating methods and procedures involved in the performance of functions under this agreement. The Carrier agrees that the Secretary shall, at such times and in such manner as he may prescribe, have access to such Information, and, further, if more than 50 percent of the cost of development thereof has been paid out of Government funds, shall have use of such Information for health care or health care financing programs under the Act.

D. The Carrier shall retain such Information or data subject to the time limit imposed by Article XXI on the retention of the Carrier's records and the right to examine such records as specified in such Article.

E. The Carrier shall establish and maintain procedures and controls for the purpose of assuring that information contained in its records and obtained from the Secretary or from others in carrying out its functions under this agreement shall be used by it and disclosed solely as provided in section 1106 of the Act and Regulations of the Secretary prescribed thereunder.

F. The Carrier shall not use its position as a Medicare contractor for purposes of furthering its private business interests or gain, nor shall the Carrier use any materials or information it obtains from the Secretary or develops in performing its functions under this agreement to promote its private business interests.

G. The Carrier shall establish and maintain procedures and controls (including the completion of an ap-

propriate conflict of interest questionnaire) for the purpose of preventing any of its directors, trustees, officers or responsible employees from using their positions with the Carrier for purposes of furthering their private business interests, to the detriment of the Medicare program, and from using any material or information, not otherwise in the public domain, obtained by the Carrier from the Secretary or developed by the Carrier in performing its functions under this agreement to promote their private business interests. Furthermore, as a condition for the approval or renewal of this agreement, the Carrier shall supply the Secretary with such ownership and control interest information as required by section 1124 of the Act (P.L. 95-142, Sec. 3+ and such Regulations as may be promulgated by the Secretary pursuant thereto.

H. The Carrier shall establish and maintain procedures and controls for the purpose of preventing any of its directors, trustees, officers or responsible employees, directly or indirectly, from accepting payment from any person of any fee, commission, compensation, gift, or gratuity as an inducement or acknowledgement for the award of a subcontract.

I. The Carrier (or a parent, subsidiary, or affiliated organization) shall not perform, in any jurisdiction in which it is serving as Carrier, billing services for a physician or supplier of other medical services where billings by such physician or suppliers of other medical services are to be subsequently processed for Medicare program payments.

Article XII

HEARING PROCEDURE

The Carrier shall establish and maintain procedures, in conformity with Regulations and General Instructions prescribed by the Secretary, pursuant to which an eligible individual or his assignee will be granted an opportunity for a fair hearing by the Carrier when requests for pay-

ment under Part B of Title XVIII of the Act with respect to services furnished him are denied, or not acted upon with reasonable promptness, or when the amount of such payment is in controversy. The Carrier shall not be required to grant an eligible individual or his assignee a hearing with respect to his allegation that the Carrier is not acting with reasonable promptness upon his request for payment unless action thereon has not been taken by the Carrier within such period of time from the date of filing such request for payment, as may be specified in Regulations.

Article XIII

UTILIZATION OF SERVICES OR CARE

The Carrier shall (A) establish methods for identifying utilization patterns and, where appropriate, bring such patterns to the attention of the proper professional groups, (B) institute utilization safeguards which include methods of assuring that payments made for Part B services are for covered services which are medically necessary; and if after application of the safeguards and appropriate investigation, the Carrier concludes that a service or services for which a claim has been made were not medically necessary or that the claim as presented is improper in reflecting the amount and character of services rendered, the Carrier shall adjust or deny the claim. For the purposes of this Article, the Carrier shall have the services of a duly licensed medical practitioner available.

Article XIV

CERTIFICATION AND DISBURSEMENT

The ~~Carrier~~ shall establish and maintain adequate procedures and controls to insure that any payments pursuant to this agreement are made only upon proper certification and/or authorization. In establishing and

maintaining such procedures, the Carrier shall provide for separation of the functions of certification and disbursement. The Carrier shall give a fidelity bond to the United States in such manner and in such amount as the Secretary may deem appropriate.

Article XV

INDEMNIFICATION

A. In the event the Carrier or any of its directors, officers, or employees, or other persons who are engaged or retained by the Carrier to participate directly in the claims administration process, are made parties to any judicial or administrative proceeding arising, in whole or in part, out of any functions of the Carrier under this agreement in connection with any claim for benefits by any individual or his assignee or provider of services, then the Secretary shall hold the Carrier harmless for all judgments, settlements, and costs, in favor of such individual or his assignee or provider of services, incurred by the Carrier or any of its directors, officers, or employees, or other persons who are engaged or retained by the Carrier to participate directly in the claims administration process, in connection therewith. The Carrier shall reimburse the United States for the amount of any valid judgment or award paid by the United States in the discharge of the Secretary's obligations under this Article if the liability underlying the judgment or award was the direct consequence of conduct on the part of the Carrier, determined by judicial proceedings or the agency making the award to be criminal in nature, fraudulent or grossly negligent.

B. If the Carrier is either list developer and/or list holder for the Secretary's Second Surgical Consultation Program, the same protection as described in paragraph A above shall also apply to any judicial or administrative proceedings arising from those activities.

Article XVI

TYPES OF COSTS ALLOWABLE FOR ADMINISTRATION OF THIS AGREEMENT

A. It is the intent of this agreement that the Carrier, in performing its functions under this agreement, shall be paid its costs of administration under the principle of neither profit nor loss to the Carrier.

B. The Secretary shall pay to the Carrier the total amount of allowable costs of the Carrier incurred in the performance of this agreement subject to Article XVII. The costs allowable under this agreement shall be determined in accordance with the provisions of section 1-15.2 of the FPR, as interpreted and modified by Appendix B to this agreement, provided, however, that the Carrier may appeal, in accordance with paragraph H of Article XVII of this agreement, any cost determination by the Secretary. The Carrier's method of allocating indirect costs, if equitable, reasonable, and in accord with generally accepted accounting principles applicable to the Carrier's business, and in accordance with Article XVI of Appendix A, shall be accepted by the Secretary in establishing the cost of performing this agreement.

C. In connection with the allowability of any particular item of cost, the Carrier may from time to time submit to the Secretary a request as to whether such item of cost is allowable. A written communication from the Secretary to the Carrier that such item of cost is allowable shall constitute a determination of allowability for purposes of this agreement.

D. Any costs which are properly chargeable by a provider of services as benefit costs in accordance with the Act and Regulations, shall not be chargeable to this agreement as administrative costs.

E. In the event the Carrier or any of its directors, officers, or employees, or other persons who are engaged

or retained by the Carrier to participate directly in the claims administration process, are made parties to any judicial or administrative proceeding arising, in whole or in part, out of any function of the Carrier under this agreement, except any proceeding of the type to which reference is made in Article XV, the amounts of any judgment, settlement, costs, expenses, or other expenditures directly or indirectly incurred by the Carrier or any of its directors, officers, or employees, or by other persons who are engaged or retained by the Carrier to participate directly in the claims administration process, in connection with such proceeding shall be reimbursable.

Article XVII

COST OF ADMINISTRATION

A. The Carrier shall submit to the Secretary, for his approval, at such times and in such form as the Secretary may determine, an estimate of administrative expenses to be incurred by the Carrier corresponding to the Federal fiscal year. Such estimates shall include cost estimates accompanied by supporting documents. The Carrier may at any time submit appropriate revisions to the budget which reflect modifications in its cost estimates.

B. The Secretary and the Carrier shall negotiate the amount of the annual budget, and any revisions thereto, based on the estimates submitted by the Carrier, in an amount calculated to pay the costs of administering this agreement. After the negotiations between the Secretary and the Carrier on the amount of the annual budget and any amendments thereto, the Secretary shall issue a notice specifying such budgeted amount. Such budgeted amount for the purpose of obligation of funds by the Secretary shall be a ceiling which the Carrier may not exceed without prior approval of the Secretary or as subject to paragraph F. If there are any modifications

to this agreement during this term, the budgeted amount shall be amended to allow for such modification. On the basis of such estimates as the Secretary shall approve, a quarterly allotment of funds will be determined by the Secretary for the fiscal year. The Carrier or its authorized bank may withdraw funds for such fiscal year through the letter of credit, as specified in Article VIII of this agreement, but not in excess of each cumulative quarterly allotment, unless the Carrier obtains written approval of the Secretary for withdrawing amounts in excess of such allotment. The Carrier shall establish such fiscal and accounting controls as may be necessary in order to comply with the provisions of this Article.

C. The Carrier shall have no obligation under this agreement to incur any costs (1) beyond its budgeted amount, as it may be revised from time to time, or (2) in the event the Secretary fails to approve a requested increase in the Carrier's quarterly allotment of funds, beyond the cumulative amount previously determined by the Secretary for such quarter; provided, however, that if costs in excess of the indicated amount are in fact incurred by the Carrier, its rights under paragraph F of this Article will in no event be prejudiced thereby.

D. If variances in excess of 5% in the amounts budgeted for any quarter for any component of administrative expenses for the Carrier are reported, the Secretary may require from the Carrier explanations of such variances from the budget approved in accordance with paragraph B of this Article for the purpose of avoiding budget cost overruns in each component. For purposes of this agreement, the components of administrative expenses are those Groups of budget items set forth in section 4351 of the Medicare Carriers Manual as in effect on October 1, 1978. If the Secretary or the Carrier determines that such variances from the budget require an adjustment in the budget, such adjustment shall be accomplished by such ways and means as may be agreed

to by the parties, or, if the parties are unable to agree, by abatement of any activity or activities performed or to be performed by the Carrier, by adjustment in the budget, or by a combination of both budget adjustment and abatement of activities as the Secretary may direct; provided, however, that the allowability of any costs incurred by the Carrier in the implementation of any abatement directed by the Secretary shall be governed by the provisions of paragraph B of Article XVI of this agreement applicable to termination costs. The principles set forth in Section 1139 of Appendix B to this agreement, governing termination costs, shall be applicable as appropriate to costs related to the abatement under this paragraph.

E. If at any time it appears to either party that the budgeted amount will not be sufficient to cover administrative costs incurred and/or estimated to be incurred in the fiscal year, such party shall so notify the other promptly, but in no event less than 60 days prior to the date on which it is estimated that budgeted funds will be exhausted unless it can be demonstrated that such notice could not have been given 60 days in advance of such estimated date. Such notification may be by telephone or telegraph with later confirmation by letter and shall contain proposals as to how costs expected to be incurred may be reduced. The Secretary and the Carrier shall promptly negotiate ways and means of resolving the matter for the purpose of assuring that the Carrier will not suffer a loss in the performance of its contractual obligations. Such resolution may include an increase in the budget, a reduction of functions to be performed by the Carrier, a combination of both, or such other ways and means as may be agreeable to the parties. If, after negotiating in good faith, the parties are unable to find a satisfactory solution to the matter, the Secretary shall give the Carrier written notice as to what measures to take in order to avoid the incurrence of

costs in excess of the budgeted amount or available funds. Notwithstanding any other provision of this agreement, if the Secretary notifies the Carrier to abate the performance of a function, the obligation of the United States, if any, shall not extend beyond the effective date of the notice to abate or the date such notice is received, whichever is later. Provided, however, that the allowability of any costs incurred by the Carrier in the implementation of any abatement directed by the Secretary shall be governed by the provisions of paragraph B of Article XVI of this agreement applicable to termination costs. The principles set forth in section 1139 of Appendix B to this agreement, governing termination costs, shall be applicable as appropriate to costs related to the abatement. Any time period specified in this section may be waived by mutual agreement of the parties.

F. If the amount of costs incurred by the Carrier which are determined to be allowable upon final settlement exceeds the budgeted amount, the Secretary shall pay such allowable costs provided that the requirements of paragraphs D and E, as applicable, have been met by the Carrier.

G. The Carrier, as soon as possible, but not later than three months after the expiration of each Federal fiscal year, unless the Secretary approves a different time period or fiscal year, shall submit to the Secretary a report, including supporting data, of the allowable costs incurred by it during the Federal fiscal year. Negotiations on final determination of the administrative costs of the Carrier shall be undertaken by the Secretary and the Carrier as rapidly as possible after the Secretary's receipt of the Carrier's final statement. A closing agreement with respect to those items of administrative costs which they agree are allowable shall be incorporated into a memorandum signed by the Secretary and the Carrier, and such determination shall constitute a final determi-

nation that such costs are payable to the Carrier for the fiscal year. Such items of cost on which the Secretary and Carrier are unable to agree shall continue to be negotiated and if not resolved shall be subject to a subsequent determination by the Secretary in accordance with paragraph H, below.

H. If the Secretary and the Carrier are unable to agree upon a final determination of the administrative costs of the Carrier for a particular period, the Secretary shall determine such administrative costs for such period and inform the Carrier of such costs, with a full explanation of the exceptions he has taken to the Carrier's report of its allowable costs. The determination of the Secretary on a question of fact shall be final and conclusive unless, within 30 days from the date of receipt of the written notice to the Carrier of such exceptions, the Carrier files a written appeal with the Secretary. The decision of the Secretary upon such appeal shall be final and conclusive upon the Carrier, unless a court of competent jurisdiction finds such decision to have been fraudulent, or capricious, or arbitrary, or so grossly erroneous as necessarily to imply bad faith, or not supported by substantial evidence. In connection with any appeal proceeding under this Article, the Carrier shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. The representatives of the Secretary who hear the appeal and make the decision shall be different from the representative who determined the exceptions. Pending the decision of the Secretary, the Carrier shall proceed diligently with the performance of this agreement and in accordance with the exceptions taken.

The previous provisions of this paragraph do not preclude consideration of any question of law in connection with decisions provided therein, except that nothing in this agreement shall be construed as making final such decisions on a question of law.

I. After the determination of the allowable cost(s) either by mutual agreement between the Secretary and the Carrier, or after the application of the provisions of paragraph H of this Article, the Secretary will make such adjustments as may be necessary in accordance with the provisions of the following subparagraphs:

(1) If for the fiscal year the amount of funds withdrawn under the letter of credit, by the Carrier or its authorized bank, as specified in Article VIII is in excess of the amount of such allowable costs, the Carrier will refund to the Secretary any excess.

(2) If for the fiscal year the amount of funds withdrawn under the letter of credit, by the Carrier or its authorized bank, as specified in Article VIII, is less than the amount of such allowable costs, the Secretary will pay the difference to the Carrier.

Article XVIII

PRIOR APPROVAL AND PRIOR NOTICE FOR SUBCONTRACTING AND DATA PROCESSING CHANGES

A. The Carrier shall not enter into any subcontract with a third party to perform any of the functions set forth in this agreement unless such subcontract received the prior written approval of the Secretary.

B. The Carrier may enter into subcontracts, not controlled by paragraph A above, which are necessary for the performance of the work required under this agreement, except that the prior written aproval of the Secretary shall be required for any subcontract entered into in whole or part for the administration of the Medicare program when:

1. The estimated cost to Medicare over the term of such subcontract will exceed $150,000, irrespective of the percentage of the cost of such subcontract to be charged to Medicare.

2. For purposes of subparagraph 1 of this paragraph, the estimated cost to Medicare of a lease of real property for a term of more than 1 year shall be the amount of the rental payment estimated to be allocable to Medicare for the first year of the lease.

In the event that said subcontract is entered into jointly with another Medicare contractor, the Carrier shall secure the prior written approval of the Secretary if the aggregate amount of said subcontract attributable to Medicare exceeds the higher of the individual amount assigned to either party.

Where the total monetary amount of the subcontract attributable to Medicare is not specifically identifiable at the time the subcontract is entered into, but could reasonably be anticipated to exceed in the aggregate the limits set forth in subparagraph B 1, then the Secretary's prior written approval shall be required. In the event the aggregate costs to be charged to this agreement under a subcontract which at its inception did not require the prior approval of the Secretary exceeds or it becomes apparent will exceed, the amount set forth in subparagraph B 1, the Carrier shall immediately request approval of the Secretary to continue with the subcontract and if the Secretary disapproves such continuance, the Carrier shall then terminate it at the earliest date permitted under the wording of the subcontract itself.

C. Where the Carrier submits a proposed subcontract for the approval of the Secretary, such approval shall be deemed to be granted unless the Secretary notifies the Carrier within 60 days of receipt thereof that such proposed subcontract is disapproved.

D. The Carrier shall provide the Secretary with written notice as described in Article XX at least 60 days in advance of any planned automated data processing systems or operations change involving the Medicare claims process where the estimated cost to Medicare for either (1) the conversion and implementation of the planned

change or (2) the increase in operating costs during the first twelve months of operation of the planned change, exceeds the threshold amount specified in paragraph B 1 above. The Carrier shall not implement the change without the prior written approval of the Secretary. Approval of any proposed change, including subcontracts related thereto, shall be deemed to be granted unless the Secretary notifies the Carrier of his disapproval within 60 days of receipt of notice of the proposed change or proposed subcontract. If the Carrier proceeds with the proposed change or proposed subcontract related thereto without the prior approval of the Secretary, if required, the United States will not be obligated to reimburse the Carrier for costs incurred with respect to such change or subcontract prior to the date of such approval unless so stipulated.

E. Prior written approval given by the Secretary under any of the provisions of this Article shall not be construed to constitute a determination of the allowability or unallowability of any costs under this agreement unless so stipulated.

F. Any proposed modification or amendment to a subcontract which required the written approval of the Secretary, shall be submitted for the Secretary's prior approval where the estimated cost of such proposed change or changes would result in an increase of the costs to Medicare in excess of fifty percent of the threshold amount.

Before a subcontract which has been approved by the Secretary is renewed or any option contained therein is exercised, the Secretary's approval shall be obtained, unless the Secretary has stipulated otherwise in writing.

G. If, with respect to any subcontract entered into under this Article requiring the prior written approval of the Secretary, such required approval is not obtained, the United States shall not be obligated to reimburse the Carrier for any additional costs incurred, relative to such subcontract, prior to the date of the Secretary's approval unless so stipulated.

H. The requirements for prior written approval may be waived by the Secretary when the exigencies are such that requiring prior written approval would be administratively impracticable and such waiver is secured in advance of the execution of the subcontract or the implementation of any proposed change as described in paragraph D of this Article. Both the waiver and the request for waiver should be made by telephone or telegraph with later confirmation by letter.

I. Without regard for the requirements of prior approval under this Article, the Carrier shall give the Secretary advance notification of any subcontract which provides for payment on a cost-plus-fixed-fee-basis, regardless of amount, or any fixed price subcontract which results in payment by the Secretary of more than $25,000.

Article XIX

SUBCONTRACTING

A. The provisions of this Article shall apply unless otherwise stipulated to subcontracting under this agreement without regard for the requirements of prior approval.

B. It is the policy of the Government to procure property and services from responsible sources at fair and reasonable prices calculated to result in the lowest ultimate cost to the Government. In order to achieve this objective, competitive proposals shall be utilized to the maximum practical extent.

C. Where competition is not available or does not yield reasonable subcontract prices, the Carrier shall also be required to undertake appropriate price analysis in accordance with Part 1-3.807-2(b) of the Federal Procurement Regulations and to undertake cost analysis in accordance with Part 1-3.807-2(c) of the Federal Procure-

ment Regulations in all subcontracts subject to approval of the Secretary under paragraph B of Article XVIII.

D. For any subcontract or modification of a subcontract entered into or renewed under this agreement where the estimated cost to Medicare under the subcontract exceeds $100,000 and is not based on adequate price competition, established catalog or market prices of commercial items sold in substantial quantities to the general public, or prices set by law or regulation, the Carrier shall, in accordance with Parts 1-3.807-3, and 1-3.807-4 of the Federal Procurement Regulations, require the subcontractor to submit written cost or pricing data and certify that the cost or pricing data submitted was accurate, complete, and current prior to the entry into the subcontract or modification of a subcontract. The Carrier further agrees, through inclusion in all such subcontracts, to require subcontractors to maintain full and complete accounting records to support cost or pricing data submitted aforesaid, to require subcontractors to provide for full access by the Carrier, the Secretary, and the Comptroller General of the United States for the purpose of examining the accuracy of cost or pricing data submitted as aforesaid, and in accordance with parts 1-3.807-5 and 1-3.814-3 of the Federal Procurement Regulations to agree to a reduction in price if the cost or pricing data submitted is found to be defective.

E. Any subcontract under paragraph A of Article XVIII, or any subcontract entered into or renewed under this agreement involving automated data processing systems or services shall provide to the Secretary or his representative:

1. The right to inspect fully any and all work performed or being performed thereunder either directly by the subcontractor or through arrangement with another party;

2. The right to obtain and use freely any data acquired or utilized by the subcontractor in the development and processing of claims or carrying out its functions under the subcontract;

3. The right to review without limitation all systems documentation, program logic, operating manuals, and all other operating methods and procedures involved in the performance of functions under this agreement. Further, if more than 50 percent of the cost of development thereof has been paid out of Government funds, the Secretary shall have use of such information for health care or health care financing programs under the Act.

F. Any subcontract under paragraph A of Article XVIII, or any subcontract entered into or renewed under this agreement providing for the development of, or study of the feasibility for development of, a data processing system (including an automated data processing system), management procedures, internal or Medicare program instructional material or operating methods shall specify that the work product so produced shall inure to and remain the property of the Carrier if more than 50 percent of the cost or price of such subcontract is to be paid from funds for the administration of programs under the Social Security Act, and further that the Secretary or his representative shall have the right of free and unrestricted use without further cost.

G. Any subcontract under paragraph A of Article XVIII or any subcontract entered into or renewed under this agreement involving automated data processing systems or services which required the prior approval of the Secretary shall provide that no lower-tier subcontract for the performance of any functions or parts thereof of such subcontracts can be entered into without prior written approval of the Secretary. Further, such subcontracts shall provide for the Comptroller General of the United States and the Secretary (including their duly authorized representatives) the same right to examine subcontractor

records as is provided in Article XXI B of this agreement.

H. Any agreement between the Carrier and a medical consultant engaged by the Carrier to review Medicare claims, or health care utilization or to perform related services shall be deemed not to constitute a subcontract for purposes of this agreement.

I. The Carrier agrees to insert in its subcontracts under this agreement the applicable articles of Appendix A.

J. The Carrier agrees that no subcontract under this agreement shall provide for payment on a cost-plus-a-percentage-of-cost basis.

K. It is understood and agreed that the foregoing provisions of this Article are not by way of limitation upon the Secretary's right, at the time of prior approval, to require the Carrier to specify other terms and conditions requisite upon subcontractors performing functions under this agreement.

Article XX

DATA PROCESSING

A. In submitting data processing proposals for approval of the Secretary such notification as required in Article XVIII D shall include: 1) the design specifications and cost analysis of the proposed change, and 2) documentation that such change or process is needed and is cost effective.

B. When subcontracting, as provided in Article XIX, the Carrier shall design data systems specifications, equipment performance requirement specifications, and other specifications to foster free and open competition and opportunity to responsible suppliers, including manufacturers, leasing companies and third party vendors.

Article XXI

EXAMINATION OF RECORDS

A. The Carrier shall maintain adequate accounting records covering the use of funds under this agreement. The Carrier agrees that the Secretary and the Comptroller General of the United States (including their duly authorized representatives) until the expiration of 3 years after final payment for the term of this agreement or of the time periods for particular records specified in Part 1-20 of the Federal Procurement Regulations (41-CFR Part 1-20), whichever expires earlier, shall have access to and the right to examine upon reasonable notice and at all reasonable times any directly pertinent books, documents, papers, and records of the Carrier, and those of any parent, affiliated or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the Carrier, involving transactions related to this agreement.

B. The Carrier further agrees to include in all subcontracts under this agreement, a provision to the effect that the subcontractor agrees that the Secretary and the Comptroller General of the United States (including their duly atuhorized representatives) until the expiration of 3 years after final payment for the term of the subcontract or of the time periods for particular records specified in Part 1-20 of the Federal Procurement Regulations (41-CFR Part 1-20), whichever expires earlier, shall have access to and the right to examine any directly pertinent books, documents, papers, and records of subcontractors, and those of any parent, affiliated or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the subcontractor, involving transactions related to the subcontract. For purposes of this Article the term "subcontract" excludes (1) purchase orders not exceeding $10,000 and (2) subcontracts or purchase orders for public utility

services at published rates established for uniform application to consumers.

C. The periods of access and examination described in paragraphs A and B, above, for records which relate to (1) appeals under the "Disputes" clause of this agreement, (2) litigation or the settlement of claims arising out of the performance of this agreement, or (3) costs and expenses of this agreement as to which exception has been taken by the Comptroller General or any of his duly atuhorized representatives, shall continue until such appeals, litigation, claims, or exceptions have been disposed of.

D. Each period this agreement is in effect, including automatic renewals, as specified in Article XXVII shall be a separate term of this agreement for purposes of this Article and "final payment" for a term of this agreement shall be deemed to have occurred on the date of the memorandum, specified in paragraph G of Article XVII, setting forth the administrative costs for such term, or on the date the final decision is made on appeal under paragraph H of Article XVII.

Article XXII

INSPECTION AND EVALUATION

A. The Secretary shall have the right to appraise Carrier performance under this agreement. The Secretary shall also have the right, at all reasonable times, and upon reasonable notice to the Carrier, to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. Pursuant thereto, the Secretary shall have the right to maintain onsite representatives on the premises of the Carrier.

B. If any inspection or evaluation is made by the Secretary on the premises of the Carrier or a subcontractor, or onsite representatives of the Secretary are maintained

on the premises of the Carrier, the Carrier shall provide and shall require his subcontractor to provide all reasonable facilities and assistance for the safety and convenience of the Secretary's representatives in the performance of their functions. All inspections and evaluations of the Secertary's representatives shall be performed in such a manner as will not unduly delay work. If a written report of such inspection or evaluation is prepared which reflects Carrier deficiences or proposed corrective action to be taken by the Carrier, a copy shall be furnished to the Carrier. Any corrective action proposed to be taken as a result of such inspection or evaluation shall be discussed with the Carrier prior to implementation.

Article XXIII

DISPUTES

A. Except as otherwise provided in this agreement, any dispute concerning a question of fact arising under this agreement which is not disposed of by agreement shall be decided by a duly authorized representative of the Secretary who shall reduce his decision to writing and mail or otherwise furnish a copy thereof to the Carrier. This decision shall be final and conclusive unless, within 30 days from the date of receipt of such copy, the Carrier mails or otherwise furnishes to the Secretary a written appeal. The decision of the Secretary or his duly authorized representative for the determination of such appeals shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, or capricious, or arbitrary, or so grossly erroneous as necessarily to imply bad faith, or not supported by substantial evidence. In connection with any appeal proceeding under this clause, the Carrier shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. Pending final decision of a dispute hereunder, the Carrier shall proceed diligently with

the performance of the contract and in accordance with the Secretary's decision.

B. This disputes clause does not preclude consideration of law questions in connection with decisions provided for in paragraph A above: Provided, that nothing in this contract shall be construed as making final the decision of any administrative official, representative, or board on a question of law.

C. Disputes concerning the interpretation or application of Regulations and General Instructions or administrative procedures in connection therewith shall not be subject to the provisions of this Article. In addition, this Article shall not apply to termination of this agreement under Article XXIX, Termination of Agreement.

Article XXIV-

COMPLEMENTARY INSURANCE

A. The Carrier's complementary insurance claims process may be integrated with its Medicare claims insurance process in accordance with Regulations and General Instructions. When the insurance processes are totally or partially integrated, all direct costs shall be charged to the appropriate line of business and indirect costs shall be prorated on appropriate allocation bases consistent with the Carrier's established principles of allocating indirect costs as stipulated in Article XVI B. It is understood that a cost center must be allocated if the activity in the cost center benefits both Medicare and the complementary claims process. Where the claims processes are separate, the Carrier will bear the costs of transferring to its own operation data needed on a routine or occasional basis in a manner prescribed by the Regulations and General Instructions. Where agreement has not been reached on cost determinations concerning complementary insurance matters, these disputes will be subject to the fiscal disputes procedures of Article XVII.

B. The Medicare Claims information which the Carrier has access to for its own complementary insurance program may be disclosed to itself and to other complementary insurers but only in accordance with section 1106 of the Act and the Regulations prescribed thereunder.

Article XXV

APPENDICES

The Appendices, A and B, attached hereto are part of this agreement.

Article XXVI

CONTINUANCE OF FUNCTIONS UNDER PRIOR AGREEMENT

It is understood and agreed that the continuance of performance after September 30, 1978, of any function undertaken under the agreement between the Carrier and the Secretary pursuant to section 1842 of the Act in effect prior to October 1, 1978, shall be deemed to be performed under and subject to the terms of this agreement. It is further understood and agreed that any subcontract entered into by the Carrier with the approval of the Secretary the term of which extends beyond September 30, 1978, shall remain in full force and effect until the expiration date thereof where such subcontract shall be terminated prior to the expiration date in accordance with the provisions thereof or where such subcontract shall require further approval by the Secretary in accordance with paragraph F of Article XVIII of this agreement.

Article XXVII

TERM OF AGREEMENT

This agreement shall begin on October 1, 1978, and end on September 30, 1979. It will automatically be re-

newed for successive periods of 1 year unless the Carrier or the Secretary gives written notice of intention not to renew the agreement at least 90 days before the end of the current period.

Article XXVIII

MODIFICATION OF AGREEMENT

A. This agreement may be modified at any time by mutual consent of the parties thereto.

B. If the Secretary finds that because of enactment of P.L. 92-603 or any other subsequent legislative changes, modification of this agreement is necessary to carry out the provisions of the Act, as amended, or to perform experiments and demonstration projects pursuant to legislative enactment, he may modify any of the functions, parts thereof, or any other services to be performed by the Carrier. Prior to any such modification, the Secretary shall afford the Carrier an opportunity to consult and participate in planning for adjustments which might be necessary and thereafter provide the Carrier written notice that the modification is to be made within 90 days after a date specified in the notice.

C. The Carrier may enter into arrangements as approved by the Secretary with a Professional Standards Review Organization for purposes of implementation of Title XI of the Act. To the extent that any function of the Carrier under this agreement is assumed by the Professional Standards Review Organization under the arrangements approved, the Secretary shall waive performance of such function by the Carrier and will notify the Carrier in writing of such waiver.

D. Within 10 days of receipt of the Secretary's notification provided in paragraph B of this Article, the Carrier may terminate this agreement upon 90 days written notice to the Secretary, and shall not be required to im-

plement any modifications of this agreement provided for in such notification during such 90 day period.

E. Any costs referred to in Article XXIX of the agreement, as being applicable if incurred at the termination of this agreement, shall be allowable if incurred in the effectuation of any of the aforementioned provisions.

Article XXIX

TERMINATION OF AGREEMENT

A. This agreement may be terminated at any time by mutual consent of the parties thereto.

B. If the Secretary finds, after reasonable notice and opportunity for hearing to the Carrier, that:

(1) the Carrier has failed substantially to carry out this agreement, or

(2) the Carrier is carrying out this agreement in a manner inconsistent with the efficient and effective administration of Part B of Title XVIII of the Act, the Secretary may terminate this agreement at any time.

The opportunity for hearing to the Carrier as provided under this paragraph shall be conducted in accordance with the hearing procedures as contained in the Health Care Financing Administration Regulations entitled, "Federal Health Insurance for the Aged and Disabled," 42 CFR 419ff.

C. If this agreement is terminated by the Secretary and/or the Carrier in any manner provided in this agreement (including nonrenewals under Article XXVII), any funds advanced to the Carrier under this agreement which have not been expended or encumbered in accordance with the terms of this agreement prior to the date the agreement was terminated shall be returned to the Secretary and any funds determined to be due the Sec-

retary or the Carrier after the application of Article XVII shall be paid to such party. Prior to final payment under this agreement, the Carrier shall execute and deliver an assignment to the Secretary, in such form as he may prescribe, of refunds, rebates, credits, or other amounts (including interest thereon) properly allocable to costs for which the Carrier has been reimbursed under this agreement. In determining the amount due to either party, reimbursable costs shall be determined in accordance with paragraph B of Article XVI.

D. Any costs referred to under this Article shall be allowable if incurred in the implementation of any of the aforementioned provisions.

Article XXX

PRIVACY ACT

The Privacy Act of 1974, Public Law 93-579, and the Regulations and General Instructions issued by the Secretary pursuant thereto, are applicable to this agreement, and to all subcontracts thereunder to the extent that the design, development, operation or maintenance of a system of records as defined in the Privacy Act is involved.

AGREEMENT NO. HCFA 78-313-2

In Witness Whereof, the parties hereby execute this agreement this 13th day of December, 1978.

THE SECRETARY OF HEALTH,
EDUCATION, AND WELFARE

By: /s/ [Illegible]
Acting Director
Medicare Bureau
(Title)

Pan American Life Ins. Co.
(Carrier)

By: /s/ Norris V. Fitzmorris
Senior Vice President
Public Relations and
Medicare Operations
(Title)
2400 Canal Street
New Orleans, La.
(Address)

NOTE: Carrier, if a corporation, should cause the following certificate to be executed under its corporate seal, provided that the same officer shall not execute both the agreement and the certificate.

CERTIFICATE

I, F. Donald Gibson, cerify that I am the Vice President Secretary Treasurer of the corporation named as Carrier herein; that Norris V. Fitzmorris, who signed this agreement on behalf of the Carrier, was then Sr. Vice President of said corporation; that said agreement was duly signed for and in behalf of said corporation by authority of its governing body, and is within the scope of its corporate powers.

/s/ F. Donald Gibson
(Corporate Seal)

Supreme Court, U.S.
FILED
APR 15 1988
JOSEPH F. SPANIOL, JR.
CLERK

No. 87-1331

In the Supreme Court of the United States

OCTOBER TERM, 1987

PAN-AMERICAN LIFE INSURANCE COMPANY, ET AL.,
PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF HEALTH
AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MEMORANDUM FOR THE RESPONDENT IN OPPOSITION

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Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MEMORANDUM FOR THE RESPONDENT IN OPPOSITION

Petitioners contend that the court of appeals erred in issuing a writ of mandamus ordering the district court to dismiss the Secretary of Health and Human Services (HHS) as an involuntary plaintiff in petitioners' suit under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. (& Supp. III) 1001 *et seq.*, where the purpose of making HHS an involuntary plaintiff was to force it to litigate in a United States district court a contract dispute over which the court had no jurisdiction.

1. The Contract Disputes Act of 1978 (CDA), 41 U.S.C. 601 *et seq.*, establishes an exclusive mechanism for resolving most disputes arising out of government contracts. Under the CDA, contractor claims against the government and government claims against a contractor are initially considered by a contracting officer, who issues a written decision on each claim (41 U.S.C. 605). The

CDA provides that, following that decision, a dissatisfied contractor may either appeal to the agency's board of contract appeals (41 U.S.C. 606)—from which review is available in the Court of Appeals for the Federal Circuit under 41 U.S.C. 607(g)(1)—or bring an action directly on the claim in the United States Claims Court (41 U.S.C. 609).[1] The CDA does not permit the initiation or review of contract claims in the district courts. See *ibid.* To the contrary, 28 U.S.C. 1346(a)(2) explicitly denies the district courts jurisdiction of any claim "founded upon any express or implied contract with the United States * * *."

2. Between 1966 and 1980, HHS awarded a series of contracts to petitioner Pan-American Life Insurance Company (Pan-American) under which Pan-American was to process certain Medicare claims within the State of Louisiana. The contracts provided that Pan-American would be reimbursed for administrative costs, and between 1966 and 1984 Pan-American charged the Medicare program almost $3 million for pension costs for Pan-American employees working on the contracts. The last Medicare contract with Pan-American was terminated on December 31, 1984. Pursuant to the terms of that contract (see note 5, *infra*), an adjustment of previously allowable pension costs was to be made at the time of termination. A preliminary audit revealed that HHS had overpaid Pan-American in the amount of $2,759,828. Pet. App. 17a-19a, 30a-32a.

After the termination of the contract, former participants in the Pan-American Life Insurance Company Employees' Retirement Plan filed suit against Pan-

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[1] Originally, the CDA provided for appeals to the United States Court of Claims, which was abolished by the Federal Courts Improvement Act of 1982, Pub. L. No. 97-164, 96 Stat. 25. The trial functions of the Court of Claims have been transferred to the Claims Court.

American in the United States District Court for the Eastern District of Louisiana (Pet. App. 16a-31a). The complaint alleged that the employees had a stake in approximately $6 million in pension benefits they alleged should have been paid to employees for work done for Pan-American in connection with the Medicare contracts (Pet. App. 28a-29a). Plaintiffs sought "an allocation of the plan as delineated in [29 U.S.C. 1344]."[2] HHS was not named as a defendant in this action.

3. At plaintiffs' suggestion, and over HHS's objections, the district court joined HHS as an involuntary plaintiff pursuant to Fed. R. Civ. P. 19(a) (Pet. App. 1a). The apparent effect of this order would be to require HHS to litigate in this case in the district court its claim for repayment of any amounts it may have overpaid Pan-American for pension costs. On January 20, 1987, the Secretary moved for dismissal of HHS arguing, inter alia, that the district court lacked jurisdiction over any contract dispute between HHS and Pan-American because 28 U.S.C. 1346(a)(2) denies the district courts jurisdiction over such disputes. At the same time the Secretary sought leave for HHS to appear as amicus curiae to apprise the court of the government's interest in the disputed funds (Pet. App. 58a-62a).[3]

The district court denied the motion to dismiss and denied the motion to appear amicus curiae as moot (Pet. App. 2a). The Secretary then filed a motion to certify the denial of the motion to dismiss for interlocutory appeal

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[2] 29 U.S.C. 1344 provides that "[i]n the case of the termination of a single-employer defined benefit plan, the plan shall allocate assets of the plan" according to a statutorily defined formula.

[3] At that time, HHS had not asserted a formal claim against Pan-American for overpayment on the contract since only a preliminary audit had been completed. A formal claim has since been asserted in the amount of $2,678,135.

pursuant to 28 U.S.C. 1292(b). When the district court denied this motion (Pet. App. 3a-4a), the Secretary petitioned the court of appeals for a writ of mandamus directing the district court to dismiss the Secretary from the case. The court of appeals granted the petition, noting that a writ of mandamus was "the only available means to accomplish review of the district court's jurisdiction at this stage of the proceedings" (Pet. App. 5a).

4. The decision of the court of appeals is correct and does not conflict with any decision of this Court or of any other court of appeals. Further review is therefore unwarranted.

a. The government asserts a contract claim against a contractor by means of a written decision issued by the contracting officer. 41 U.S.C. 605(a). This decision is "final and conclusive and not subject to review by any forum, tribunal, or Government agency, unless an appeal or suit is timely commenced as authorized" in the CDA. 41 U.S.C. 605(b). The CDA provides that the final decision of a contracting officer may be challenged either by appealing to the board of contract appeals (41 U.S.C. 606) or by filing an action in the Claims Court (41 U.S.C. 609). The districts courts have been expressly denied jurisdiction over such claims. 28 U.S.C. 1346(a)(2) ("the district courts shall not have jurisdiction of any civil action or claim against the United States founded upon any express or implied contract with the United States or for liquidated damages in cases not sounding in tort which are subject to sections 8(g)(1) and 10(a)(1) of the Contract Disputes Act of 1978 [41 U.S.C. 607(g)(1) and 609(a)(1)]").

On October 27, 1987, after the writ of mandamus was issued to the district court in this case, the government contracting officer issued a final decision finding that Pan-American owed the government $2,678,135 in overpayments. A demand letter asserting this claim was sent to

Pan-American. Because the 90-day period in which to appeal to the agency board of contract appeals has now expired (41 U.S.C. 606), Pan-American, if it chooses to contest this claim, must file a direct action in the Claims Court. HHS cannot, directly or indirectly, be forced to litigate the claim in the district court. Nor could HHS have been forced to litigate the claim prematurely in the district court prior to issuance of the contracting officer's final decision.

b. Petitioners attempt to evade the jurisdictional limitations of the CDA in two ways. First, petitioners argue (Pet. 8-14) that, because the employees' suit against Pan-American arises under ERISA and because HHS may have an interest in some of the same funds in which the employees assert an interest, the government's contract claim also arises under ERISA and, hence, falls within the general federal question jurisdiction of the district court (28 U.S.C. 1331). This argument is patently wrong. HHS does not have an ERISA claim against Pan-American; it has a claim for overpayment under the Medicare contract, which may be heard only by an agency board of contract appeals or in the Claims Court.[4]

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[4] It is clear that a claim by HHS against Pan-American for overpayment does not fall within Section 502 of ERISA, 29 U.S.C. 1132 (providing for civil enforcement actions). "ERISA carefully enumerates the parties entitled to seek relief under § 502; it does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action for a declaratory judgment on the issues of this case. A suit for similar relief by some other party does not 'arise under' that provision." *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 27 (1983).

Petitioners' reliance (Pet. 8-11) on *Metropolitan Life Ins. Co.* v. *Taylor*, No. 85-686 (Apr. 6, 1987), and other cases from this Court discussing when ERISA preempts state-law claims and when ERISA-related suits should be heard in federal rather than state court is misplaced. No such questions are presented here. No ERISA issues are

Second, petitioners contend (Pet. 16-18) that the CDA does not apply to HHS's claim against Pan-American because the original contract between HHS and Pan-American was entered into before the effective date of the CDA. See 41 U.S.C. 601 note (CDA applies "to contracts entered into" on or after March 1, 1979). This argument fails for two reasons. First, the overpayment dispute does not concern a breach of any obligation under the 1966 contract. It concerns the obligation under the 1980 contract to settle any overpayment or underpayment in the pension fund at the time of the termination of the contract, an event that occurred in 1984.[5] Article XXIII of the 1980 contract expressly states that "[t]his agreement is subject to the Contract Disputes Act of 1978."

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implicated in the dispute between HHS and Pan-American. In *Northeast Dep't ILGWU Health & Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 156-159 (3d Cir. 1985), upon which petitioners also rely (Pet. 13), the court found federal question jurisdiction in a dispute between two rival ERISA plans that was not explicitly authorized by ERISA on the theory that the courts would have to apply a "federal common law" of ERISA to resolve the dispute. But the contract dispute between the Secretary and Pan-American does not involve the application of ERISA law at all. It is purely a government contract dispute to be resolved in the forums provided by Congress.

[5] Article XXIX of the 1980 contract (a copy of which has been lodged with the Clerk) provides in pertinent part that upon termination of the agreement "any funds advanced to the Carrier under this agreement which have not been expended or encumbered in accordance with the terms of this agreement prior to the date the agreement was terminated shall be returned to the Secretary and any funds determined to be due to the Secretary or the Carrier after application of Article XVII shall be paid to such party." Article XXVI of the 1980 contract provides that any functions undertaken pursuant to prior agreements and continued in the 1980 agreement "shall be deemed to be performed under and subject to the terms of this agreement."

Second, jurisdiction would not in any event lie in the district court over a dispute concerning payments made pursuant to contracts entered into prior to the effective date of the CDA. Prior to the enactment of the CDA, contract disputes where the amount in controversy was more than $10,000 were within the exclusive jurisdiction of the Court of Claims. 28 U.S.C. (1976 ed.) 1491 (see note 1, *supra*). The amount claimed by the Secretary here is substantially more than $10,000. Thus, even under pre-CDA law, the contract dispute over this amount would not have been within the jurisdiction of the district court.

It is respectfully submitted that the petition for a writ of certiorari should be denied.

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APRIL 1988

U.S. GOVERNMENT PRINTING OFFICE: 1988—202-037/60405